

NATIONAL QUALITY FORUM

+ + + + +

EMERGENCY DEPARTMENT
QUALITY OF TRANSITIONS OF CARE EXPERT PANEL

+ + + + +

WEDNESDAY
APRIL 26, 2017

+ + + + +

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

PRESENT:

STEPHEN CANTRILL, MD, FACEP, Co-Chair; Denver Health Medical Center, University of Colorado School of Medicine

JANET NILES, RN, MS, CCM, Co-Chair; President, Niles Associates, Inc.

DONNA CARDEN, MD, Professor, Emergency Medicine, University of Florida*

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

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

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:

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:

GREGG MARGOLIS, MS, PhD, NRP, Director, Division
of Health Systems and Health Policy, HHS

JESSICA OIDTMAN, MS, Policy Analyst, Emergency
Care Coordination Center, Division of
Healthcare System Policy, HHS

* present by teleconference

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

Welcome, Recap of Day 1	
Stephen Cantrill, MD, FACEP, Co-Chair. . . .	5
Panel Presentations	
Dr. Jesse Pines -	
Provider Communication	6
Kyle Cobb -	
Patient Communication.26
Kirsten Reed -	
Engagement of the Broader Community.70
Marcia Wilson -	
Achievement of Outcomes.77
Define Measure Concepts -	
Small Group Breakout	102
Break.	102
Small Group Report Back.	103
Public and NQF Member Comment.	133
Lunch.	134
Panel Discussion - Recommendations for	
Strengthening ED Performance Measurement	135
Public and NQF Member Comment.	199
Next Steps/Timeline.	202
Adjourn.	207

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

2 8:29 a.m.

3 CO-CHAIR CANTRILL: Good morning.

4 It's 8:30. Welcome back. We have quite an
5 extensive schedule today. In fact we've made a
6 couple of changes.

7 Yesterday we did a lot of good work.
8 And what we thought about doing is changing
9 things a little bit so we really go in some
10 degree of detail with presentations from each of
11 the different panels in terms of what they found,
12 the gaps they found.

13 And we do want to engender a
14 discussion from the rest of the panel for each of
15 the presentations. Specifically, looking across
16 the different domains and see are there areas of
17 commonality between the different groups.

18 And also ask questions. If things are
19 vague or they're not clear to you, ask questions
20 in terms of clarification.

21 So we're going to be doing that from
22 now until 9:30. And then at 9:30 we'll be going

1 into our breakout group.

2 And the breakouts will run for an hour
3 and a half. We'll be back at 11:00 for the
4 report backs.

5 If there are any issues, we will give
6 you Foley catheters if necessary. But, so we
7 have quite an extensive day.

8 So to -- I think we'll get right into
9 it. And we'll start with the first group, the
10 provider communication. Jesse, could you give us
11 a summary of what you guys did yesterday?

12 We do have slides. And the slides
13 are, I think were handed out. And they will be
14 emailed to you as well.

15 DR. PINES: Sure. So, thanks
16 everyone. I hope everyone had a nice dinner last
17 night. Unfortunately I couldn't join you. But,
18 I heard it was a nice event.

19 So, for provider communication we took
20 the -- basically the 24 measures and ultimately
21 there were only a couple of measures that were --
22 we thought were really relevant. And sort of

1 could be potentially used today.

2 We actually took a lot of the existing
3 measures and we said this is, you know, directly
4 relevant. But we would recommend sort of
5 tweaking that measure.

6 What we ended up doing is also sort of
7 redefining, so the subdomains. Specifically when
8 it came to combining the domain of key
9 information and also for properties of the
10 transition.

11 And also combined the two subdomains
12 for feedback and for shared accountability. And
13 well, you can see here, hopefully we can get the
14 slides up there. Is that the -- this was the
15 ultimate definition that we came up with.

16 Basically the subdomain one, which is
17 key information and its properties. And gave a
18 list of some basic information elements that
19 could be useful in transitions.

20 And then also talked a little bit
21 about the properties. Specifically modality,
22 timeliness, efficiency, salience, accuracy, et

1 cetera. So let's go to the next slide here.

2 And then this is the ultimate
3 definition we came up with for shared
4 accountability and feedback. And I think
5 everyone should have a printout.

6 And you can sort of read through what
7 we came up with. And I guess at 9:30 we're going
8 to be going through and taking a closer look at
9 that.

10 But if you have any feedback for our
11 group, I think that would be helpful. If you go
12 to the next slide.

13 We also -- there were again, sort of
14 24 measures. We went through a lot of what we
15 thought were actually directly relevant to
16 transitions.

17 But, sort of, you know, for example
18 there were several measures where -- of inpatient
19 transitions in care that could be potentially
20 modified for the emergency department.

21 There were two measures that we
22 thought were directly relevant. Actually the --

1 this NQF 0291 to 0297.

2 Which is actually seven different
3 measures that look at patient who are being
4 transferred out of healthcare facilities. Which
5 as we know is common in the emergency department.

6 And it's basically about having
7 specific information elements sent within a
8 specific period of time, usually within 60
9 minutes. And you can see what those are.

10 Basically having the whole record and
11 all this, you know, important information when
12 we're actually receiving a patient coming into
13 the emergency department with a transition for an
14 ED transfer or an ED to inpatient transfer. It's
15 important to sort of have the information
16 actually either go with the patient or arrive
17 shortly after so the tests don't have to be
18 duplicated.

19 Or that, you know, that the receiving
20 group can have the most information about what
21 happened during that first visit, whether it be
22 an emergency department admission -- emergency

1 department visit or potentially a hospital
2 admission. Which so these measures actually
3 apply to both anyone being transferred outside of
4 the facility.

5 There were also some -- there was also
6 an asthma specific care coordination measure that
7 defined some key information and properties about
8 basically having a notification of the specialist
9 within 24 hours. Or the PM, primary medical
10 doctor, primary care physician within 24 hours.

11 And also some sort of follow up within
12 72 hours. This was for asthma. And you can see
13 in our measure concepts, we think it's important
14 to sort of blow out this to develop some broad
15 transition measures, specifically for high risk
16 transitions, you know, asthma being one chronic
17 condition that would potentially meet that
18 inclusion criteria.

19 But again, so of the 24 measures,
20 there were really not that many that we thought
21 could be sort of used today. However, a lot of
22 the measure concepts were overlapping.

1 And if you go to the next slide here,
2 these were some of the sort of measure concepts.
3 And this is where we spent a lot of our time.

4 There was a medication reconciliation
5 measure that applied to the primary medical
6 doctor, the PCP. That when the PCP sees a
7 patient that there is a medication reconciliation
8 about what happened under sort of the -- in the
9 post-acute care timing.

10 You know, commonly this can be applied
11 to inpatient admissions. But also we think that
12 this is important to happen after an emergency
13 department visit.

14 But we also think that because the
15 emergency physicians are maybe making that
16 medication change that there should be a
17 medication reconciliation on sort of both ends.
18 And this would be, I think, a good example where
19 there would be shared accountability between,
20 assuming there is a primary medical doctor to
21 refer to the patient to, between the emergency
22 department and the PMD.

1 And that that would be sort of again,
2 an example of shared accountability. And it also
3 could be an example where feedback could be given
4 to the -- to sort of both ways about sort of the
5 -- about the transition in care.

6 The next one was sort of the broad
7 sort of transitions in care measure. There were
8 actually sort of a lot of different flavors of
9 transitions in care measures either coming out of
10 the emergency department or to primary care
11 physicians.

12 So these are all sort of post-ED
13 transfers that we think is directly relevant.
14 And actually, you know, I think is really
15 important about the concepts of notification of
16 an ED visit.

17 So, that should happen within a, you
18 know, a short period of time. That the PMD
19 should receive an ED discharge summary.

20 And you can see here I put time
21 periods TBD. Because those sort of varied
22 across, you know, varied based on the different

1 metric.

2 There was also this concept again of
3 a documented follow up visit after an ED visit.
4 Which in our discussions we don't necessarily
5 want to have sort of proscribed follow up, in
6 person follow up.

7 But, what we think that it is
8 important that patients do receive some sort of
9 check in. Whether that's in tele-medicine, it
10 could be an email that, you know, are things
11 going okay?

12 Because as we know, not only after
13 people are discharged from the hospital, that's a
14 high risk period. After people are discharged
15 from the emergency department, that can also be a
16 high risk period.

17 And also similarly, medication
18 reconciliation. Yes, Marcia?

19 DR. WILSON: Yes. I want to just make
20 a point here that the team was talking about this
21 morning with the co-chairs.

22 Is, as Jesse's going through these,

1 and we're going to move through these very
2 quickly, if you take something like medication
3 reconciliation or follow up that's kind of
4 ubiquitous in the transition. You know, that
5 belongs to all of us.

6 And I'd like to point out that you're
7 working within a domain that takes a certain
8 perspective of an activity like follow up. The
9 parsing into the -- when you take something like
10 follow up that goes across domains, it's a little
11 artificial to say domain one owns this piece of
12 it. Domain two owns this piece of it.

13 The point is, when you think about
14 follow up, what is appropriate for provider
15 communication to measure? That's the perspective
16 they're thinking.

17 In the outcomes domain, we were
18 thinking of follow up from a different
19 perspective. So what's possible is you could
20 have follow up measures in each domain.

21 They're measuring something slightly
22 different. The perspective is different. So, as

1 you're hearing about the other domains, think
2 about, is that in my domain? How do I think
3 about it?

4 Again, it will all come together in
5 the final report. And it does seem a little
6 artificial now. But we're pushing you to say, in
7 terms of follow up, what does the provider worry
8 about? What does a patient worry about? What is
9 how -- what does that have to do with community
10 engagement? What does that have to do with
11 outcomes?

12 Because we want to get to the most
13 robust measures and measure concepts possible.
14 So, go ahead Jesse. Sorry.

15 DR. PINES: Great. So, we also talked
16 that there were several measures related to
17 primarily behavioral health patients as sort of a
18 high risk population having, you know, care plans
19 in the emergency department for behavioral
20 health.

21 However, we thought that those --
22 there was actually a lot of programs out there

1 that have demonstrated sort of great utility to
2 ED care plans. Not just for behavioral health,
3 but for a number of other high risk populations,
4 frequent users of the emergency department for a
5 variety of reasons whether it be for chronic pain
6 or chronic comorbidities, sickle cell disease,
7 that sort of thing.

8 And we think that that is sort of a
9 key potential area for measure development.

10 Where, you know, those programs have been
11 particularly successful in being able to deploy
12 sort of a standardized care pathway for a patient
13 who comes into the emergency department
14 frequently, and one that is actually coordinated
15 with a primary care medical home with the primary
16 care physician.

17 We also discussed a lot of the, you
18 know, concepts of feedback. And we think that
19 feedback is vital for the, you know, basically
20 for any system where there is provider to
21 provider communication, where patients are sent
22 between settings where there maybe different

1 education or different expectations across
2 settings.

3 We think it's important to have both
4 a feedback system from the emergency department
5 directly to referral settings, from -- you know,
6 certainly from a primary care physician who is
7 sending a patient to the emergency department.
8 You know, obviously sending the information back.

9 But, also, you know, other types of
10 settings who maybe sending patients in, urgent
11 care centers, nursing homes. So, to really have
12 sort of a good understanding of what happened in
13 the emergency department.

14 And to give feedback so those
15 providers can learn the capacities and
16 capabilities of an emergency department. And
17 maybe able to sort of better differentiate sort
18 of who needs to go, and also as a way to sort of
19 optimize referrals. Marsha?

20 DR. WILSON: In terms of feedback and
21 outcomes, we had a very robust discussion about
22 when the ED doctor needs feedback on what

1 happened, and setting limitations there. Because
2 you don't want to inundate the emergency
3 department physician with feedback on every
4 single patient.

5 But what I hear you talking about
6 feedback as a learning experience. So, I think
7 if you could flesh that out in your breakout.

8 DR. PINE: Yes.

9 DR. WILSON: Is that we're not talking
10 about feedback on what happened to the patients.
11 It's feedback as a system of care in the system
12 of care.

13 DR. PINES: Yes. And you know, and I
14 think it could be used for both purposes. And so
15 -- and particularly in episodic settings.

16 You know, these are not patients that
17 in the emergency department we're going to see
18 people over time. An urgent care center is going
19 to see a patient again.

20 But, to have, you know, to give
21 feedback on helpful cases that, you know, that
22 could be useful for learning about. You know, if

1 a patient had, you know, some sort of an odd
2 diagnosis, if a patient had a, you know, a
3 positive test.

4 For a patient who is sent in, and the
5 urgent care center sent the patient in, and they
6 ultimately didn't actually get the test or care
7 that they thought the patient should have
8 received in the emergency department.

9 Then you know, we sort of see this
10 frequently between settings where, you know, one
11 provider will think that the patient needs some
12 sort of treatment or diagnostic test. And then
13 the next provider who sees them may not agree.

14 So, developing a system to -- sort of
15 a learning system to be able to give feedback,
16 you know, not in every single transition in care,
17 but ones that could be useful for learning.

18 And then when it comes to the
19 longitudinal care providers, those physicians,
20 family physicians, internists, pediatricians,
21 those physicians should also receive feedback on
22 the test results itself. So next slide.

1 Some of the other measure concepts.
2 We thought that the concept of a sort of a
3 checklist would be -- could be useful.

4 Particularly for high risk
5 transitions. High risk transitions are something
6 that would obviously need to be sort of clearly
7 defined based on either patient comorbidities,
8 you know, observable characteristics such as age
9 and comorbid conditions.

10 Or also, something related to what's
11 in the foreground of the transition itself. You
12 know, sort of why the patient is being
13 transferred.

14 And this is where, you know, it
15 wouldn't necessary come under the purview of this
16 particular committee, but, you know, someone
17 could consider developing sort of a taxonomy of
18 different types of transitions. And how those --
19 how the different types of transitions would lead
20 to specific check lists for specific types of
21 patients.

22 Which I think is ultimately what we

1 want. You know, obviously one that sort of
2 creates work where it's helpful. And does not
3 create undue burden.

4 And I think that sort of threading the
5 needle there is going to be a challenge. Also
6 the concept of sort of measuring whether or not
7 people are getting follow up for chronic
8 diseases.

9 You know, if a patient who has
10 hypertension and has a very elevated blood
11 pressure, to make sure that, you know, this could
12 be measuring at the system level. Are these
13 patients getting follow up when follow up is
14 requested.

15 You know, particularly for conditions
16 that are high risk. In a short term where
17 there's some sort of red flagged diagnosis.

18 We also talked about there were a
19 number of measures that we didn't talk about in
20 detail. But they were actually in the list of
21 potential measures.

22 About having accessibility of pre-

1 hospital encounter data in the EHR. You know,
2 some systems it take -- it can take up to 24
3 hours to get the pre-hospital records into the
4 EHR.

5 And also there were several EMS
6 measures that I think our group is going to be
7 talking about in more detail. Specifically
8 measures of the percentage of EKGs that are
9 transmitted pre-hospital, for cath lab
10 activations, which is a, you know, common sort of
11 structure that's out there.

12 The percentage of large vessel
13 obstruction patients who are taken to
14 comprehensive stroke centers. You know, there's
15 a new treatment for stroke that's very effective,
16 but only about two hundred hospitals out there
17 can actually deliver it.

18 And sort of getting those patients to
19 the right hospitals. And also the percentage of
20 terminally ill patients with post -- with end of
21 life instructions where they don't necessarily
22 want a lot of invasive care.

1 The percent that are actually
2 transferred to the emergency department. And
3 with a goal for that to would be -- for that to
4 be low. Next slide.

5 These were some of the other concepts.
6 You know, looking at percentage of patients where
7 there's some adverse social determinants are
8 identified prior to discharge. There was a
9 little bit of discussion in our group around
10 that.

11 You know, I think we're going to be
12 probably talking a little bit more about that.
13 And whether, you know, what we do with that
14 information in the emergency department, whether
15 or not that's truly a measure of quality.

16 It has been, you know, actually
17 several consensus conferences in emergency
18 medicine that have focused on social determinants
19 and what we do. At risk patients where there's
20 some sort of alerting of the PMD.

21 Notification for fall victims. And
22 also home assessments by -- completed following a

1 referral by ED staff. Janet?

2 CO-CHAIR NILES: Yes. I think that
3 number one there, the percentage of patients, is
4 one that we talked about in our group with the
5 social.

6 DR. PINES: Yes.

7 CO-CHAIR NILES: So it maybe one --
8 that's one of our cross cutting measures --

9 DR. PINES: Yes.

10 CO-CHAIR NILES: That belongs probably
11 in both. Or maybe move over to the community
12 piece.

13 DR. PINES: Yes. I totally agree with
14 that. So the next slide here, we also talked
15 about some gaps in measurement.

16 I thought that one of the sort of most
17 valuable things out there is to really have
18 information about advanced directives. You know,
19 obviously when the patient arrives at the
20 emergency department and not three hours in when
21 we've already started delivering care.

22 There were really no measures around

1 the accuracy of information. You know, I think
2 that, you know, that's another area where we
3 could develop some measures.

4 There were also not that many measures
5 around sort of information transfer. And
6 specifically, you know, systems that could be
7 built to facilitate information transfer.

8 Because there are not that many
9 systems today that actually exist. And you know,
10 there are a few examples out there of systems
11 that exist. But they're certainly not
12 ubiquitous.

13 And then finally, you know, basically
14 sort of trying to sort of reconsider it. And I
15 think we'll have some discussions about this.
16 Really thinking about sort of what we mean by
17 follow up.

18 You know, when we say that a patient
19 should be follow up within a specific period of
20 time, a high risk patient, what that actually
21 means. And how that could be measured. Next
22 slide.

1 I think that was all of the group.

2 Yes. Yes.

3 CO-CHAIR CANTRILL: Any comments or
4 questions for Jesse? I think one of the
5 challenges is -- oh, Kyle, go ahead.

6 MS. COBB: Yes. I know, Janet didn't
7 want me to speak. So, I'm going too anyways.

8 Just on a similar vain of measures
9 that maybe -- or concepts that maybe sort of
10 cross cutting or amenable to another domain. I'm
11 wondering about the EMS measures and the assess -
12 - or the concepts rather of EMS.

13 And the accessibility of pre-hospital
14 encounter data. And just thinking about how when
15 we think about the community and how that sort of
16 links out, and sort of connecting the dots if you
17 will.

18 Those maybe better concepts for the
19 engagement of the broader community.

20 DR. PINES: Yes Some of the EMS
21 measures are related to specific sort of EMS
22 actions that would be not dependent upon the

1 community.

2 MS. COBB: Okay.

3 DR. PINES: So, you know, the -- so if
4 someone, you know, if they find -- you know,
5 let's say they're called for a fall at home and
6 they put someone back in bed, and whether or not
7 that information goes to the primary care
8 physician.

9 Whereas, certain ones so, you know,
10 for the percentage of patients that are taken to
11 comprehensive stroke centers with LVO. That that
12 would certainly be dependent on that community
13 actually having that resource.

14 MS. COBB: Well, and I'm -- I guess,
15 this is where we get into definitions. But I'm
16 curious to understand also if EMS is the
17 community?

18 Like and where does the ED end and,
19 you know, what do we consider to be the
20 community.

21 DR. PINES: Yes.

22 MS. COBB: So, I mean, I guess that's

1 some homework for the community group and
2 provider group. But I'm curious to hear what
3 other people's thoughts are.

4 CO-CHAIR CANTRILL: Well EMS was also
5 part of our group, the outcomes group too. For
6 some of the same items in terms of
7 interoperability of information. And -- Julie,
8 I'm sorry. Go ahead.

9 MEMBER MASSEY: In talking about the
10 EMS within the community, I think what we also
11 have lost some -- the -- or I learned more about
12 the connections to other emergency providers.

13 So, fire rescue and the police, and
14 some of the other community that we don't
15 traditionally think of as part of our healthcare
16 community as closely as EMS. But that they -- we
17 need to find ways to reach out to other community
18 resources outside of the ED, to help support our
19 patients.

20 CO-CHAIR CANTRILL: Okay. Any other
21 comments or questions? I'm sorry. Yes, Karin?

22 MEMBER RHODES: So, I think in this

1 context, an EMS provider who is directly handing
2 a patient off to the ED provider is really, you
3 know, part of the provider communication. And
4 it's a huge gap that exists that you don't
5 actually, you know, one you've had a home visit.

6 And the opportunity is there for
7 communicating information and how the patient was
8 in the field are frequently lost. Especially if
9 they're wheeled in, but in a bed, and the EMS
10 takes off and the record doesn't show up for a
11 few days.

12 It's a, you know, -- so I think that
13 it's a pretty critical piece to keep in the
14 provider communication. And then the only other
15 comment I had is the -- around the social
16 determinants.

17 That I like that that's in there. I
18 think it implies routine screening for social
19 determinants in the emergency department if we're
20 going to -- because that's the only way they'll
21 be routinely collected and identified.

22 And then so it maybe moves to outcomes

1 as to what you do once you identify them. But, I
2 think this implies some routine screening.

3 DR. PINES: And just the other -- the
4 concept of sort of adding, you know, adding
5 questions to when a patient comes to the ED or
6 every patient walks into the emergency
7 department.

8 There already is a, you know, a big
9 database of sort of, you know, questions that
10 must be asked around safety at home. And
11 they're, I don't know, 15 questions that everyone
12 is asked.

13 And you know, I think we've got to
14 really sort of carefully consider, what do we do
15 with that information. Especially if we're
16 adding that sort of, you know, generating more
17 data.

18 MEMBER DUNFORD: Good morning. Just
19 to amplify a little bit on the issue of the other
20 pre-hospital providers.

21 One of the common ones would be police
22 departments bringing in mentally ill patients

1 involuntarily to hospitals. And I know of some
2 hospitals in Pennsylvania years ago that were
3 already measuring the time to turnover, because
4 law enforcement can't stick around.

5 And so being good citizens, emergency
6 departments really have this responsibility to
7 kind of release the police as soon as possible.
8 So it becomes, you know, not only the interface
9 and the handoff, but basically an efficient
10 timely handoff.

11 So, I think that's a simple one that
12 can be measured. And also reflects connectivity
13 through the community. And recognition that
14 they're providers.

15 And you guys probably have a lot of
16 psychiatric emergency team people that are being
17 partnered with police officers these days, and
18 that kind of thing.

19 CO-CHAIR CANTRILL: Okay. Let's move
20 onto the next group, patient communication. And
21 Kyle, you're going to lead us through here.

22 MS. COBB: Okay. Good morning. So,

1 for the -- just as a recap of where we landed.
2 Yesterday we winnowed the subdomains down to
3 four. And kept key information and modality.

4 And really saw key information as
5 being two types of information. Whether it be
6 the healthcare team to the patient care. And
7 then the patient care to the healthcare team.

8 And we had a conversation around
9 exactly what types of data or information would
10 be provided by the care of patient -- patient
11 care to the healthcare team.

12 And specifically we -- it really went
13 into the conversation around like, what burden,
14 burden for the patient, what does the patient
15 need to provide? And do we measure that? Is it
16 fair to measure that?

17 And we -- and I'm really curious to
18 get feedback from the rest of the panel on this.
19 We spoke about advanced directives. We spoke
20 about just patient preferences, medications,
21 specifically over the counter medications, and
22 herbs and other types of supplements that may not

1 be as part of a med-rec list.

2 So, that -- those were just areas that
3 had been identified. And I believe also just to
4 recap that there was some conversation around
5 consent.

6 And it came up that, you know, there
7 was a discussion around HIPAA. And how in most
8 cases that the consent would be, you know, there
9 was no need for it.

10 But we did, in our breakout, identify
11 a couple of instances specific to pediatrics or
12 minors and mental health. I think there was
13 another one, that we felt were gray areas. And
14 where you may want to think about consent.

15 So, for modality, I think we have
16 looked at a bunch of different types of
17 modalities and analog and digital and all of
18 that.

19 And then for the patient needs
20 verification, which I think really addresses a
21 lot of the more sort of communication, but really
22 effective communication areas around, you know,

1 has your anxiety been addressed? Have your needs
2 been addressed?

3 What -- and there are more qualitative
4 aspects of the care process. But really part of
5 the shared decision making that we wanted to
6 really capture through measurement.

7 And then finally risk assessment.
8 Which I have been sort of challenging myself over
9 the past few hours around whether it really is a
10 subdomain. Or it's risk assessment just gets
11 woven through as Marsha mentioned earlier,
12 through everything that we think about.

13 And the assumption is that when we
14 think about whatever the key information is, or
15 the modality, or the communication, it's a
16 result, and it's a deliberate result of risk
17 assessment. So, I'm curious to hear people's
18 thoughts on that. Next slide.

19 CO-CHAIR CANTRILL: Brenda?

20 MS. COBB: Or even sooner.

21 MEMBER SCHMITTHENNER: With regard to
22 the patient's needs verification, does that also

1 include the patient preferences? The patient's
2 goals?

3 MS. COBB: It does. So, and our
4 working definition is really a series of
5 questions right now.

6 But we have, are the concerns of the
7 patient being addressed? Has the patient's
8 anxiety been relieved? Did the communication
9 provided informational support?

10 We are considering the salience of
11 information. Was it provided in a culturally
12 sensitive way? And shared decision making.

13 MEMBER SCHMITTHENNER: I would
14 recommend also adding, you know, what is the
15 patient's goals?

16 MS. COBB: Okay.

17 MEMBER SCHMITTHENNER: Because they
18 maybe very different then --

19 MS. COBB: Yes. Agreed. I'm putting
20 it in right now.

21 CO-CHAIR CANTRILL: I think one of the
22 challenges though is designating for what

1 patients does that apply. Gunshot wound to the
2 chest, I'm not going to be discussing goals with
3 this guy.

4 You know, so I think -- and that's
5 really the challenge for some, I see, for so many
6 of these things. The documentation of ED follow
7 up, you know, which patients?

8 MS. COBB: I think it goes back to
9 this -- the idea of a risk assessment. And what
10 does that mean?

11 CO-CHAIR CANTRILL: And what does that
12 mean? And how do we do it? And how far can we
13 get with that? Yes. Exactly.

14 MS. COBB: Yes. Is it a sniff test?
15 Or is it a formal risk assessment?

16 And I hope that when I come in with my
17 gunshot wound, you're just doing a sniff test.

18 (Laughter.)

19 MS. COBB: Doesn't take too long.

20 CO-CHAIR CANTRILL: We're just doing
21 a chest one.

22 MS. COBB: Okay. Sounds good. Okay.

1 Any more comments? Karen?

2 CO-CHAIR CANTRILL: Marc?

3 MEMBER PRICE: So along the same
4 lines, I think a lot of the measures that we
5 talked about with the prior communication also
6 were highly dependent on what the type of visit
7 was. But that was with the follow ups with,
8 what we're going to ask, how we're going to take
9 care of the patient.

10 So, that's not a -- that's not an
11 isolated comment about it depends on what the
12 reason for the visit is. I think that's an
13 overlying theme with a lot of these.

14 CO-CHAIR CANTRILL: Karin, do you have
15 a comment?

16 CO-CHAIR NILES: Microphone?

17 DR. WILSON: Oh, do we have too many
18 mics on?

19 MEMBER RHODES: So, in regards to
20 health literacy, language, appropriateness, or
21 availability of translation. And some sort of
22 confirmation of understanding at discharge.

1 Whether that be a sort of read
2 back/teach back, or some sort of close the loop.
3 Does this patient understand the discharge plan?
4 Are they in agreement with it?

5 And do they have access to follow up
6 care? Can they afford their medications? That
7 sort of thing ought to be at least detailed in
8 there.

9 CO-CHAIR CANTRILL: Amy?

10 MEMBER STARMER: Yes. I'm just also
11 thinking again to the kind of ways the
12 differences between the provider and the patient
13 groups.

14 And I'm thinking about how our group
15 and at the providers we had kind of collapsed the
16 information elements to be the information
17 elements. And then the properties of how those
18 information pieces are transmitted.

19 And has gotten rid of the modality
20 aspect of it. Thinking that that would be kind
21 of integrated into the kind of way in which the
22 information or the quality of the information

1 transitioned.

2 So it may make sense to have those
3 parallel across the two groups. And then I'm
4 also just kind of thinking, I guess there are
5 some information components that should be
6 communicated by just between providers.

7 But, for the most part, I would think
8 that ideally the patient is centered in part of
9 the care. And are there really different
10 elements that -- between those type of
11 individuals?

12 Or should the types of information be
13 uniform between patients as well as providers?
14 So, thank you.

15 CO-CHAIR CANTRILL: Janet?

16 CO-CHAIR NILES: Yes. Back to the --
17 your question about which patients are we talking
18 about. It seems to me that mostly we're talking
19 in these things about doing the assessment and
20 things like that.

21 About patients that are going to go
22 home or back into the community. We're not

1 talking about patients that are going to the OR
2 or upstairs.

3 So these -- that might help in the
4 definition. To think about further clarifying
5 and saying patients being discharged to home or
6 the community.

7 CO-CHAIR CANTRILL: Arjun?

8 MEMBER VENKATESH: I was just
9 thinking, I think it's parallel and related. But
10 based on Karin's comments and some of these
11 others around language and communication.

12 I thought it would help to know that
13 so the American College of Emergency Physicians
14 has a new qualified clinical data registry. To
15 develop quality measures and report them to CMS.

16 We have been trying to develop a
17 measure for the last year around communication
18 and correct language of the patients. And the
19 measures that are developed for the registry are
20 all based on -- tried to all be based on EHR
21 structure, EHR data, in order to reduce burdens
22 of quality data collection and maximize, hope for

1 the validity of reporting.

2 This is a place where, and Sam, I'm
3 looking at you, where I think the -- there is a
4 recommendation could come from this group, where
5 if we want to be able to develop measures that
6 are linguistically appropriate for patients,
7 we've got to change the standards around our
8 demographic data collection and certified EHR
9 technology in order to make that possible.

10 So right now what happens is there's
11 a pretty standard registration data set. In
12 which you will usually get in my EHR products,
13 the patient's reported first language.

14 There's not standard collection of
15 second language. And then what we need is a data
16 element -- I think that we need to collect first
17 language, second language, and then a data
18 element of preferred language of communication
19 for health.

20 And that is actually very easy to
21 incorporate into existing work flows. The
22 problem is that the existing EHR doesn't allow us

1 to capture that data in a structured format.

2 If we had that building block, then
3 you can start doing a lot of these measures. And
4 incorporate language into them.

5 And so to me, I think if we're
6 thinking about care transitions out, and if we're
7 talking about provider/patient communication, and
8 we want to make some recommendations around
9 important tools for these provider/patient
10 communication measures, then that would be one
11 that's concrete, doable.

12 And if we could get that standard
13 across all ED/EHR reporting, you can actually
14 quickly operation as a quality measure.

15 CO-CHAIR CANTRILL: And thanks Arjun.
16 And I'd like to generalize that. I think that
17 committees such as this can do a service to the
18 EHR industry.

19 When we specify measures, specify the
20 variables that the EHR should in fact be
21 collecting. Pre-tech scanning doesn't work very
22 well in EHRs.

1 So you don't want to have to end up
2 with that. If we can specify for this measure to
3 work, the EHRs have to capture this variable. I
4 think that one identifies it and does a service
5 to future measure development.

6 Stephanie?

7 MEMBER WITWER: Kind of in a similar
8 vain. I think we need to think about
9 communication for transitions as a system
10 approach.

11 So, we shouldn't be asking the ED to
12 create a list of social determinants or risk
13 assessments in isolation from the system. And
14 so, I guess similarly we need too again, go back
15 to that concept of, are there certain elements
16 that need to be collected by all of the
17 providers, be them community, primary care, ED,
18 hospital, et cetera, that help us identify those
19 social determinants that may impact the patient
20 or other risks that the patient maybe exposed to?

21 And then those are available in the
22 ED. The ED's role is then really to verify the

1 information that's already there.

2 So, we need to understand that there's
3 so many upstream elements that are in play here.
4 And if we can figure out a way to connect them
5 together, no one has to recreate information at
6 every step along the way.

7 CO-CHAIR CANTRILL: Joe?

8 MEMBER KARAN: The plan that we're
9 helping to assess and possibly be put out there
10 is a national program. Yet when you look at it
11 regionally, it's going to be affected greatly.

12 The people in Miami, in emergency
13 departments there, are going to be way different
14 than the one in Kansas City. And since the group
15 that we worked on is really based around
16 communication back and forth to the patient, we
17 can't expect this to be followed.

18 You know, we have to have some lead
19 way there for the physician and everyone else to
20 decide how to best handle their community. And
21 how do we allow this to not -- or to give more
22 free range to the physicians and the ED

1 departments?

2 How do we do that? That's the
3 question I had. Am I making any sense? Or is
4 this still too early?

5 CO-CHAIR CANTRILL: No. You are.
6 That's -- Marcia?

7 DR. WILSON: Two things in response to
8 you, Joe. I think at this point what we -- when
9 I think of it as framework, I think of almost
10 best practices.

11 It's a national issue. It's local
12 solutions. But there does need to be some kind
13 of standardization so people don't keep
14 recreating the wheel.

15 And I think what we look at as kind of
16 a global picture is, we think these would be the
17 best practices, the best measures, the best
18 concepts will be developed out. That will truly
19 help us measure quality and transitions.

20 Not everyone may adapt everything as
21 is. And the other thing too is, I hear us
22 getting a little weedy about, okay, for this

1 patient we need this element. For this patient
2 we need this element.

3 Let's think about what is that quality
4 of transition? What needs to be captured when
5 and measured, knowing that for different
6 transitions the elements maybe slightly
7 different.

8 So I just want to keep getting not too
9 weedy here. But back to -- so that was for Joe.
10 This is for Stephanie.

11 So, in the outcomes group yesterday,
12 up on the wall we have under shared
13 accountability, A,B,C. The patient comes from A.
14 They go to B, which is the ED. And they go to C.
15 They might go back to A, but often they go to C,
16 someplace else.

17 So, A,B,C. We talked about that as an
18 implied system of care. And I think Stephanie,
19 that's what you're talking about. Not an
20 integrated delivery system.

21 But that implied system of care.
22 Which we are trying to capture with this

1 framework. Patients coming into the emergency
2 department, something happens. They go out of
3 the emergency department. That's a system of
4 care.

5 So when Stephanie makes a comment
6 about core elements of information that would be
7 shared across that system of care, that's how I'm
8 thinking about it.

9 And also when we go back to the
10 outcome breakout this morning, I want to go back
11 to that and revisit it. And see if that's a
12 definition that we all as a group want to talk
13 about transitions of care, this implied system.

14 Because all of a sudden, you all are
15 connected because you're taking care of that same
16 patient.

17 CO-CHAIR CANTRILL: Jesse?

18 DR. PINES: Yes. Just to expand on
19 that a little bit. You know, I think that one of
20 the commonalities that we're going to see across
21 a lot of EDs is the EHR systems.

22 And you know, for the most part most

1 EDs have EHR systems. And if we can make
2 recommendations where some of these systems are
3 actually integrated into the EHRs themselves, so
4 regardless of if you're in a small rural
5 hospital, you may have, you know, some system
6 that, you know, that can really deliver the
7 highest quality transition, you know, for a
8 patient.

9 And really sort of push this at the
10 vendor level. And then once this is actually
11 integrated into the EHR, it's going to be on the
12 hospital emergency department, and the community
13 to sort of build those linkages, where, you know,
14 where linkages are needed.

15 So, you know, I think there are going
16 to be a lot of commonalities. But I think it's
17 absolutely true that, you know, different
18 communities and different patients are going to
19 have very different resources.

20 And then when it comes to outcomes, I
21 think the outcomes are going to be similar. You
22 know, for good transitions.

1 And you know, we don't want to -- you
2 know, we want to make sure that people understand
3 their -- understand the transitions in care.
4 That no diagnosis is missed.

5 And that, you know, sort of outcomes
6 are optimized during these transitions. And you
7 know, and the risk of transitions is going to be
8 similar, you know, across hospitals.

9 Whether you're in a rural or critical
10 access hospital, or whether you're in an inner-
11 city hospital.

12 CO-CHAIR CANTRILL: Kyle, do you want
13 to go ahead?

14 MS. COBB: Sure. So, and thank you
15 for all of the feedback.

16 So for the measures we did, our group
17 found several measures that actually were good
18 enough for key information that really did, you
19 know, illustrate what we had discussed in terms
20 of the subdomains and definitions.

21 So, there's a transition record with
22 specified elements received by discharged

1 patients. And those include the who, what,
2 where, when elements.

3 We also had patients who have received
4 a plan, an asthma action plan at discharge.
5 Again, you know, a similar -- similar to the
6 specified elements in a discharge plan, but they
7 were able to get some actionable information.

8 And then we also had, there are a
9 series of measures. But there was one that was
10 sort of more specific than the other around
11 multiple antipsychotics.

12 With -- and the key here on this
13 measure is with appropriate justification. And
14 Adam had actually felt strongly about the
15 appropriate justification being really an
16 important part of that measure.

17 And so the feedback is interesting on
18 modality. And I think our group needs to think
19 about how key information and modality play, and
20 if modality really is a subdomain. So thank you
21 for that.

22 There are a series of meaningful use

1 measures around information transfer and making
2 certain types of information available. You
3 know, in this case patient specific education
4 information, and electronic access to patient
5 portals.

6 Again, you know, whether we call it
7 modality or something else critical to the
8 patient and care communication domain. Next
9 slide, please.

10 So for the other two subdomains, and
11 I think, you know we'll start with the risk
12 assessment. And just as a side note, we had --
13 and Karin, I appreciate your remarks on those,
14 you know, and not losing it.

15 I think it had morphed from an
16 assessment of barriers. And we may want to think
17 of going back to that.

18 But that really drives more to the
19 social determinants and understanding if you can
20 fill that RX. And can you do those things.
21 Which is a different type of assessment.

22 So, I think we -- some revisiting

1 there. But there are no measures that we found
2 that actually sort of address that.

3 We did for the patient needs
4 verification and communication, there are a
5 series of follow up measures. And just to sort
6 of repeat what Marsha and Jesse had talked about
7 in terms of follow up, there's different types of
8 follow up.

9 And we'll want to see them specific
10 actions. In this case we felt like these were
11 really specific to addressing patient and care
12 anxiety and fears around discharge.

13 And making for good transitions, to
14 have these types of follow up. Whether it be,
15 you know, for mental health or for multiple
16 chronic conditions, or high risk. Next slide,
17 please.

18 For the measure concepts -- oh,
19 Marsha, did you?

20 DR. WILSON: No, no, no.

21 MS. COBB: Okay. For the measure
22 concepts, so that was -- how many measures did we

1 have? We had 15 measures. And that's what we
2 ended up with. I'm not even looking at my notes.

3 So, for the concepts these are high
4 level. We really didn't get to thinking much
5 about concepts yesterday.

6 But, we did really like -- there were
7 some measures that we sort of developed concepts
8 off of. There was a post-operative care plan
9 measure that we discussed.

10 And really, the group liked the idea
11 of a documented communication regarding a plan of
12 care after discharge. So it's something that
13 we'll think about more about how that actually --
14 how you sort of expand that.

15 And then there is a theme of discharge
16 patient follow up. And really different, we
17 discussed that there are a lot of different time
18 frames associated to this follow up.

19 And I think a little more time and
20 thought needs to be spent on what that time frame
21 is. And how you -- and what it's based on.

22 And I think, you know, in general we

1 can say it's based on that thing called risk
2 assessment. So, it depends on who you are. And
3 it's subjective.

4 CO-CHAIR CANTRILL: Nicki, you have a
5 comment?

6 MEMBER HASTINGS: Yes. Thank you.
7 And it's just following up on that last point you
8 made about who you are.

9 So for some of the measures that your
10 group is still considering, follow up after ED
11 visit for people with multiple chronic
12 conditions, I think it gets very much at that
13 point Marc was making. Which is, baseline health
14 is a really important part of risk.

15 We can see that in our own practice
16 and studies that look at risk factors for bad
17 outcomes. But the reason for the visit is a
18 really important element for that as well.

19 So if we think about a measure based
20 on baseline health alone, in certain practices,
21 outpatient practices with adult patients, we
22 could be talking about a vast proportion of their

1 patients that would be eligible for a measure
2 like this.

3 We could be talking about a 50-year
4 old with hypertension and osteoarthritis who went
5 to the ED for a URI. So in the outpatient arena,
6 we just want to be careful that we're not
7 suggesting undue burden in terms of our -- the
8 greatest practices.

9 MS. COBB: Yes. Absolutely.

10 CO-CHAIR CANTRILL: Arjun?

11 MEMBER VENKATESH: Yes. I was going
12 to save this, but it's based off of what Nicki
13 was just saying. Or it really just does.

14 I was going to save it for the next
15 domain. But maybe I'll just mention it here
16 because we're talking about it.

17 I think what I'm hearing, and what's
18 challenging here is that we're trying to say that
19 we want to focus on patients at high risk of a
20 care transition failure.

21 And so if we make a blanket measure
22 around follow up for all ED visits, we're going

1 to end up with this undue burden. And it's not
2 necessarily true that all these patients need
3 follow up immediately after.

4 On the flip side of this, there are
5 patients who are critically ill, who have an
6 acute presentation of illness that -- for whom
7 the primary need is emergency stabilization and
8 hospitalization.

9 There were -- it's a different
10 construct for care transition involved for them.
11 And so we're trying to get to this middle group.

12 We tended to sometimes toss out
13 different clinical conditions to do it. But
14 that's a hard way of doing it.

15 I think the challenge here, and I'll
16 propose this as a different way to think about
17 the measure concept is this, is we're trying to
18 get to this middle group of patients that are at
19 high risk of a care transition failure. They are
20 folks who get -- who the purpose of the ED visit
21 is an acute care reason.

22 It may often be an acute exacerbation

1 of a chronic illness. The purpose of the
2 emergency department visits of acute presentation
3 is usually risk stratification.

4 And so, it's not that they need to do
5 a question for a risk assessment. It's that the
6 three to four hours in the emergency department
7 is the risk assessment. Right?

8 It's a patient who feels short of
9 breath, has a history of diabetes and heart
10 failure. After four hours in the emergency
11 department we determine that they're not in that
12 critically ill, needs hospital, or acutely ill,
13 needs hospitalization group.

14 We say that they're okay to discharge.
15 But it's not such a minor discharge that where a
16 follow up is less important.

17 And what gets, I think, challenging
18 with quality measurement with these patients is
19 that we have always built these measures to be
20 follow up after an ED visit. And a single ED
21 visit is not necessarily a marker of risk for
22 high risk care transition.

1 In the Medicare population, we've done
2 some work that would say risk adjusted, we would
3 expect 1.2, 1.3 ED visits a year. If I told you
4 every Medicare beneficiary had one ED visit a
5 year, people would be okay with that.

6 Because it would not be surprising to
7 think that an older adult would have one acute
8 health event per year that requires an ED visit.
9 And so maybe a better construct for the measure
10 is follow up after second ED visit within a
11 specific time frame.

12 Or the measure that I just wrote down
13 here that I thought was sort of interesting is,
14 for a -- if it's a follow up measure it could be
15 follow up within a defined time frame after two
16 ED visits with discharge, as your kind of risk
17 predictor, somebody who is now -- clearly needs
18 some additional care coordination. Or something
19 along those lines.

20 Or on the flip side is, a plan level
21 measure or a community level measure of three ED
22 visits for chronic disease or acute exacerbation

1 of chronic disease in 60 or 90 days. That way
2 these start becoming intermediate outcomes.

3 I think everybody would agree that if
4 the outcome measure is that a patient shouldn't
5 have three ED visits for uncontrolled
6 hypertension, volume overload, or hyperglycemia
7 within 60 days, you would build processes. We
8 don't measure processes.

9 Let people build their own processes
10 to reduce the three ED visit rate. All right?
11 And so, they'll build that.

12 We may need structural measures of
13 capability so that they have the health
14 information technology systems, information
15 sharing, things like that to improve the outcome.
16 But if the outcome is three ED visits in 60 days,
17 everybody could agree that we could -- if that
18 went down, it would be better care coordination.

19 CO-CHAIR CANTRILL: Thanks Arjun.

20 Karin?

21 MEMBER RHODES: So, I'd like to
22 prevent that second ED visit. And certainly the

1 third.

2 And I think a lot of the reason
3 patient's return is that they didn't understand
4 the plan. Sometimes they can't get into their
5 follow up.

6 But many times they just didn't
7 understand the plan. People tend to bounce back
8 sooner in that case.

9 So, I -- one of the things that
10 patients have told us around successful discharge
11 is, they'd like a pla -- to be able to call back
12 and get clarification on the plan of care or on
13 the follow up plan. That they don't always
14 understand it at the time of discharge.

15 So I think that if there's, you know,
16 you could say patients are discharged with a
17 documented communication plan in addition to a
18 plan of care. And that might be a phone number
19 in the ED where they pull up their record and
20 clarify what the next step was.

21 Or if there's the temperature went up
22 again, here's what you ought to go. There should

1 be something that could avoid the just
2 miscommunication around that transition by
3 providing access to the patient to call back.

4 You know, not like you've had follow
5 up, you know, maybe phone follow up for high risk
6 patients. That sounds reasonable. But patients
7 define whether or not they need that.

8 So, trying to prevent that second ED
9 visit.

10 CO-CHAIR CANTRILL: Elif?

11 MEMBER OKER: So, to echo Arjun. When
12 I look at population health data around private
13 patient employer groups, we see very much the
14 same pattern.

15 The vast majority who use EDs go once,
16 maybe twice. And then there's a small sub-
17 segment of the population that are going three,
18 four, five, six, and beyond.

19 So again, a lot of the cost effective
20 efforts are focused on really those who tend to
21 be frequent users.

22 CO-CHAIR CANTRILL: Aleesa?

1 MEMBER MOBLEY: What I'm hearing when
2 I look at risk assessment is that we're just not
3 being specific enough. We can discharge the
4 patient for follow up and give them a time frame.

5 But you also need to give them a
6 specific reason for the follow up. Because as
7 you said, if you determine the patient needs
8 something, and they're like well, I'm fine with
9 it, they're not going to follow up.

10 But if you are very specific in you
11 need to follow up for your asthma, whatever, in
12 so many days. Or you need to follow up on your
13 heart failure. Not specifically your blood
14 pressure or your obesity or whatever else.

15 Because many times the patient will
16 come back into primary care practice, and they'll
17 say, I'm here for a follow up. And they don't
18 know why.

19 Or they have no idea what the
20 diagnosis is or what the reason is that they're
21 there. And then the person in primary care has
22 to start from zero trying to figure it out.

1 CO-CHAIR CANTRILL: Jesse?

2 DR. PINES: Yes. I think it's -- I
3 think really this is sort of the key is trying to
4 identify those high risk patients.

5 I think Arjun sort of mentioned sort
6 of one methodology for that. But also I think
7 it's the reason for that, you know, that follow
8 up visit is it's also important like Nicki said.

9 And really potentially observable in,
10 you know, in Medicare data. So, there could be
11 sort of a combination of different sort of
12 comorbidity factors, you know, age.

13 And also the discharge diagnosis from
14 the emergency department. So if it's, a you
15 know, a person with heart failure and a lot of
16 comorbidities, if they're there for, you know, an
17 ankle sprain that, you know, they may not need
18 follow up necessarily if they're -- unless it's
19 specifically recommended.

20 But if they're there for shortness of
21 breath, so there should be, you know, it could be
22 -- and I think that, you know, that's where the

1 work would need to happen in terms of the
2 taxonomy of sort of defining sort of high risk
3 patients.

4 Which, you know, which could be done
5 with the kind of data that you're working with.

6 CO-CHAIR CANTRILL: Brenda?

7 MEMBER SCHMITTHENNER: You know, I
8 think that we have the opportunity to learn from
9 much of the work that has happened over the last
10 five years regarding high risk, fee for service
11 Medicare.

12 CO-CHAIR NILES: Pull your mic down.

13 MEMBER SCHMITTHENNER: Okay. Sorry
14 about that. I think that we have the opportunity
15 to learn from the past several years of programs
16 and pilots that have really tested how do you
17 reduce readmissions for high risk patients?
18 Particularly fee for service Medicare patients.

19 And I think that, you know, a lot of
20 the reports that are coming out of some of these
21 pilots and programs that have significantly
22 reduced readmissions have pointed to really, what

1 are the areas that create the greatest risk for
2 these patients?

3 And the first is, polypharmacy. So,
4 making sure that the patient fully understands
5 the medication that they're supposed to be
6 taking, and what they're not supposed to be
7 taking.

8 Also, making sure that patients that
9 have multiple chronic conditions that are coming
10 back through the hospital, whether it's through
11 the ED or inpatient, if they're appropriate for
12 palliative care or hospice, they're referred to
13 those services.

14 Also the fact that there is
15 miscommunication or lack of communication and
16 hand off. To whoever it is that's going to
17 assume care for that individual after they leave
18 the acute care setting.

19 Also the fact that patients aren't
20 activated. They need to understand what they're
21 responsible for when they leave, and empowered to
22 take responsibility for that health management.

1 And the fact that they don't have
2 access or lack the social support network that
3 they need to really implement that plan of care
4 when they leave the acute care setting. So.

5 CO-CHAIR CANTRILL: Thanks Brenda.
6 Sam?

7 MEMBER WEST: So I was thinking about
8 some of Arjun's comments. And trying to measure
9 multiple ED visits for some of these patients who
10 maybe have a lack of coordination of care.

11 It seems like we'd want to be able to
12 measure kind of both -- that they have a follow
13 up care or follow up care planned.

14 But also be able to measure the
15 multiple visits to see measure -- if the quality
16 of that follow up plan is actually being acted
17 on. Or if it's more of just a checkbox measure.

18 So it seems like kind of like a paired
19 measure at that point.

20 CO-CHAIR CANTRILL: Marc?

21 MEMBER PRICE: So, I was going to save
22 this until the next slide, the gap slide. But

1 Aleesa brought it up, so I figured I'd add onto
2 it.

3 The effective communication part of
4 things is where I see you have a gap listed in
5 the next slide. And that's a huge burden when it
6 comes to the patient following up with the family
7 medicine or the primary care doctor afterwards.

8 A lot of people, like she mentioned,
9 they come in afterwards and ask, you know, I
10 don't know what happened. I don't know what the
11 actual problem was.

12 They gave me this paper. But, I don't
13 know what it says. Or I don't know exactly what
14 it means. Or what does this mean? And what do I
15 have to worry about?

16 I'm not sure if there would be a way
17 to make a measure to cover that gap where you'd
18 have someone be able to send something out after
19 the fact to get their feedback to see if they
20 actually understood. Or if there's a way to make
21 it so that you can get feedback before they left
22 if they understood.

1 I'm a big fan of the Disney
2 Corporation when it comes to their customer
3 service. And what they do a lot of times is when
4 you're there for a vacation, they'll interview
5 you while you're there.

6 They talk about your expectations and
7 see if you're meeting them or not. And what they
8 can do better.

9 They send out surveys immediately
10 after you leave. As well as usually 60 days
11 after you leave. Because after that time you've
12 gotten your credit card bill. And you've seen
13 how much you've actually paid.

14 And the reason for that is because of
15 the fact they're seeing if you're still happy
16 with your vacation after you've paid the bill.
17 Well, I know that part.

18 But my point is, sending out some type
19 of survey after the fact to see their level of
20 satisfaction with their understanding, not even
21 their care, but their understanding of what
22 happened. It may not be a bad way to measure

1 that.

2 MS. COBB: Yes. That's -- yes. And
3 that really does feed into patient experience as
4 an outcome.

5 Let's go to the next slide. And here
6 we are with the gaps. The identified gaps.

7 And you know, certainly the shared
8 decision making, effective communication,
9 education, and cultural competency. Which we
10 just received an incredible amount of feedback on
11 from the panel.

12 So, thank you. And I think that it is
13 -- we'll have to continue to explore how we can
14 reduce burden by understanding who are the high
15 risk patients.

16 And think about ways to bring back
17 learning from all of the readmissions pilots and
18 programs. And what they've learned.

19 Thank about other ways to track that
20 through the system as Arjun suggested. And not
21 necessarily the assessment being the trigger, but
22 the number of visits to catch a certain group.

1 So, thank you. I think we're going to
2 --

3 CO-CHAIR CANTRILL: Thanks Kyle. Just
4 a little bit of a time check. We've already
5 blown the shorts off of the schedule this
6 morning.

7 So, but this is all very good input.
8 So we want to keep it going. But I would ask
9 that we just -- we move along in a dispatched way
10 as much as possible.

11 Kirsten, you're up next.

12 MS. REED: All right. Well, I've been
13 known to talk too fast. So, I will try to make
14 up the lost time.

15 So, for the Engagement of the Broader
16 Community group, I think we were one of the
17 groups who had the least amount of current
18 measures in existence. So, after going through
19 the measures, we came up with one that is
20 actually useful right now.

21 Which is under the connection and
22 alignment subdomain. Just as a quick reminder,

1 we did update the subdomains from two to three.
2 And those three now are the connection and
3 alignment, the identification, documentation and
4 engagement with the patient consent of the care
5 team, and the accessibility of services.

6 So the measure that we found to be
7 useful and relevant really just focused on giving
8 patients access to their information in a timely
9 manner. That they can share it with whomever
10 they please.

11 There were also a couple of measures
12 that we thought were useful if they would be
13 repurposed. They were, as you can see by the
14 first one, extremely specific.

15 But wondering kind of, if we kind of
16 tweak it a little bit, would it be a better fit
17 for this domain. And really these focus on
18 communication with different physicians.

19 And we also found a lot of overlap
20 between our group and then the provider
21 communication group, as well as the
22 patient/provider group. So, when we were

1 thinking later today about where things are kind
2 of overlapping, I think the three of us, or our
3 three groups really have a lot of connections
4 that we can be making.

5 We also found, I think five different
6 measures that we felt were better placed in the
7 provider group. Which are listed here.

8 And they really focus on documenting
9 various communications with the patient's primary
10 care provider after a surgery. And just ensuring
11 that there was actually a documented plan of
12 care.

13 For these two, after looking back at
14 it, I think we had initially said that these fell
15 under the provider communication domain. But I
16 think after looking at them, they more focused on
17 the patient.

18 As they're really looking at whether
19 or not there was a documented plan during the
20 follow up encounter, which updated the patient's
21 improvements and mobility, pain management, diet,
22 and so on; as well as the second one here that

1 looks at reviewing the original goals of care
2 expressed preoperatively, and then updating those
3 goals as appropriate, occurring after discharge.
4 So I think all five of those can kind of be
5 repurposed to better focus on this project.

6 All right. When it came to measure
7 concepts, there were a number that had come in
8 previously. And then the group really also came
9 up with a bunch of great ones throughout our
10 conversations yesterday.

11 They were very high level. And we
12 haven't really gotten into spec'ing them out yet.
13 So when we do that, you know, we may change our
14 minds.

15 But, there are a number of them listed
16 here. And I think they really have a common
17 theme of trying to identify the community
18 supports and services, and also regular
19 maintaining -- regularly maintaining that list.

20 Also, conducting these assessments
21 around social determinants of health. Which goes
22 back to previous conversations in other groups.

1 And really look at was that referral
2 completed? Did the patient act on what you were
3 asking them to do?

4 And then I think two of the other
5 measure concepts here. I think two things that
6 we still need to really focus on today is how are
7 we defining the care team?

8 Is it the full community? Is it just
9 what the patient is defining as their care team?
10 Are we including the law enforcement and the EMTs
11 and the payers and all of those different people
12 in the care team?

13 And really going back to what Marsha
14 said earlier, is the shared accountability. So
15 who is responsible for making these connections?
16 Who should be held accountable?

17 Some more gaps. Or I'm sorry,
18 concepts. And then finally, the gaps that we
19 came across. Really the community systems of
20 care.

21 How do we close the referral loop?
22 How are we ensuring that these referrals actually

1 are going somewhere? And something's being done
2 with them?

3 And then how do we leverage payers in
4 all of this? I think they have a lot of great
5 information that could help in really engaging
6 the broader community.

7 And group, feel free to add if I
8 missed anything.

9 CO-CHAIR CANTRILL: Excellent. I do
10 have one comment. We also looked at the ACS
11 measures in terms of post-OR. And we discarded
12 those.

13 We couldn't figure out how to bend
14 those to fit in terms of the ED. But for what
15 it's worth, you guys may be brighter than we are.

16 So, Jim?

17 MEMBER DUNFORD: One of our gaps was
18 the ability to share information between health
19 and community-based organizations. So that for
20 sure, you know, the standardized ability to share
21 information was a particular challenge for us.

22 CO-CHAIR CANTRILL: Any other

1 comments? Oh, sorry. Stephanie?

2 MEMBER WITWER: Just one quick
3 comment. Another thing that we discussed was
4 also related to previous conversation about
5 repeat ED visits being sort of considered a
6 system failure if you will.

7 And so what is it about the system
8 that's driving the patient to the ED repeatedly?
9 Is there a gap in care? Or what's happening that
10 is causing that repeat ED visit?

11 CO-CHAIR CANTRILL: Aleesa?

12 MEMBER MOBLEY: Speaking of which, is
13 it possible for us to measure the number of
14 patients who come into the ED who do not have a
15 primary care provider, who are then hooked up
16 with one?

17 MS. REED: That was one of the
18 measures that actually was --

19 CO-CHAIR CANTRILL: There's the real
20 and there's the fiction to that. I mean, all of
21 us that work in EDs know that, you know, it shows
22 up the chart and it lists the PCP. And the guy's

1 -- he's clueless. I've never seen that doctor.
2 I don't know even know who he is.

3 So, I mean, part of it maybe the
4 patient's responsibility in terms of follow
5 through. But there's multiple system problems
6 there. Then yes.

7 MEMBER MOBLEY: Then maybe we were
8 asking the wrong question. Instead of do you
9 have a PCP, have you seen a provider in the last
10 however many months?

11 CO-CHAIR CANTRILL: Right. Stephanie,
12 are you done? Or are you -- sorry. Okay.
13 Marvelous. Thank you very much Kirsten.

14 It brings us kind of back on schedule
15 a little bit. She did. Marsha, you're up.

16 DR. WILSON: Okay. Let's talk about
17 achievement -- oh, Arjun?

18 MEMBER VENKATESH: I just -- we
19 discussed this in our group yesterday based off
20 that last question. That's another data element
21 that would make sense to be part of the EHR.

22 I think the question we asked right

1 now, and that all products do, and everybody's
2 doing in the emergency department is, who is your
3 PCP? Or, I'm confirming this is your PCP.

4 I think that's a different question
5 then what came up in our group yesterday. Which
6 is, who would you follow up with after this
7 emergency department visit?

8 That is also an easy question to ask
9 as part of registration work flows in almost any
10 emergency department. And I think that would be
11 a meaningful thing to add to the EHR enterprise
12 when developing these kinds of measures and
13 understanding these. Yes.

14 DR. WILSON: Thank you. And to go
15 back to the point that you made earlier Arjun,
16 when we did some work in collecting patient
17 demographic data, we wanted -- we encouraged
18 organizations to ask, what is their preferred
19 verbal language and written language.

20 And this is what we set -- and
21 obviously this is to Steve's point, that needs to
22 be baked in as a field so it's easily

1 retrievable.

2 But it's sometimes a patient wants to
3 talk or communicate with the healthcare provider
4 in one language, but they want any discharge
5 instructions or written materials in a different
6 language. So, another field to add.

7 So, achievement of outcomes. We had
8 four domains. And we did not change those
9 domains. Although we slightly expanded the
10 safety domain.

11 Under healthcare utilization and cost,
12 we originally had a measure there that we did
13 move to safety. We had no measures of provider
14 experience.

15 And under the patient, family, and
16 care giver experience, the one that we liked is
17 from work by Eric Coleman. Which is the care
18 transition measure.

19 And there's actually a 15 item survey.
20 And what we would do is pull out the transition
21 relevant questions, which were the patient's
22 perception of the transition, and what the

1 patient understood.

2 We wouldn't use all of those
3 questions. But they got to what I'm hearing,
4 which is the outcome, is did you understand?
5 Were things clear? Were your preferences
6 respected?

7 Those kind of questions. So we would
8 suggest going back to something like there's a 15
9 item care transition measure that Coleman has
10 developed.

11 To repurpose that specifically to pull
12 out what was the patient's experience with the
13 transition. Focusing on a lot of the issues that
14 you mentioned.

15 Under the safety domain, here's this
16 follow up visit again. There were a number of
17 measures about follow up. And what we didn't
18 like is they were all kind of specific or for
19 different purposes.

20 Now we felt this one was appropriate.
21 It was for a specific event. Where normally you
22 would want to have some sort of follow up visit.

1 So this was an example of a potential
2 measure. But we're going to -- when we move
3 forward to measure concepts, we'll talk more
4 about follow up.

5 The other thing we noticed with med
6 reconciliation, I bet we had 15 measures of
7 medication reconciliation for every setting,
8 every patient, every point in time. Seriously,
9 it drives us crazy.

10 So, what we're looking for is to
11 repurpose when is a medication reconciliation
12 appropriate? Being very sensitive to burden.

13 And it's some of the things that
14 you've talked about here is, you don't -- maybe
15 you don't have to do a medication reconciliation
16 at every point in every transition for every
17 patient.

18 But certainly there maybe some
19 triggers. A change in medication. An added
20 medication. A change in dosage. There maybe
21 reason to do that medication reconciliation.

22 And I made a note of paired measure.

1 It is one thing to say that the medication
2 reconciliation was done. The other measure is,
3 did the patient understand what happened during
4 that medication reconciliation?

5 So this is one that should be paired.
6 Next slide, please. Go ahead.

7 CO-CHAIR CANTRILL: Amy?

8 MEMBER STARMER: Just a point of
9 clarification. Because I know med rec has come
10 up across a lot of these groups.

11 And in this particular group with the
12 focus on outcome, to me doing a med rec or not
13 feels awfully like a check box or a process step.
14 And the true outcome seems to be more, well, was
15 there a medication error as a result of, you
16 know, a poor med rec? Or medication related
17 adverse event. And things like that.

18 So I just wonder if pushing, you know,
19 that's -- thinking about what the point of the
20 med rec process is supposed to be. And what it's
21 trying to achieve would be helpful.

22 DR. WILSON: That's interesting. And

1 we can take that back to the group this morning.

2 We were thinking, quite honestly, more
3 in terms of the patient understanding as an
4 outcome. But error is -- would be another thing
5 for us to look at this morning.

6 CO-CHAIR CANTRILL: Jesse and then
7 Julie.

8 DR. PINES: So there actually are
9 several NQF endorsed medication reconciliation
10 measures that actually go through the, you know,
11 the patient safety group. And actually that
12 actually was one of the recommendations from the
13 last iteration, to develop more outcome measures
14 related to medication reconciliation.

15 And you know, sort of the -- so I
16 think that is a big issue. But the difficult
17 thing is going to be to actually sort of specify
18 those metrics.

19 And to try to sort of, you know, sort
20 of attribute errors to medication reconciliation
21 problems. It may be tough.

22 You know, and I think that the kind of

1 work that Arjun's doing around sort of pulling
2 the EHR data is probably the best place to look
3 at some of those metrics.

4 CO-CHAIR CANTRILL: Julie?

5 MEMBER MASSEY: I think the biggest
6 challenge from having to do that again is as you
7 discussed. I will echo the difficulty in
8 measuring the quality of med rec. Particularly
9 from EHR data.

10 Very easy to see the timing of it. To
11 see what was done. But the clinical context with
12 when what is being done, is very challenging to
13 measure with discrete data, and not knowing the
14 specifics about the patient.

15 And I would echo one of the other
16 outcomes measures we talked a little bit about
17 that we said might go more to outcomes, was
18 revisits as a result of not understanding. And
19 how do we -- a particular, previous medication
20 reconciliation.

21 The patient who has two doses of meds
22 at home and doesn't know which one to stop or

1 start. So, again, challenging, looking at
2 potentially broader community pharmacy
3 involvement if we look at that.

4 And how we can improve the quality of
5 that medication reconciliation, not just the
6 process. And then how do you measure it.

7 CO-CHAIR CANTRILL: Thank you.

8 Aleesa?

9 MEMBER MOBLEY: Just to give you some
10 background to illustrate the problem that she's
11 telling you. When you have the electronic health
12 record, depending on which program you're using,
13 you can click one button and everything's been
14 reconciled, whether you read any of it or not.

15 You can reconcile certain ones. And
16 leave others pending forever. You can have
17 patients who have a supply of medications in a
18 shoebox on top of their refrigerator that you
19 will never hear about, because that's their
20 emergency pills in case they can't afford to get
21 the new prescriptions filled.

22 Medication reconciliation is a big

1 problem. But it's a big problem from many, many
2 facets. And a simple checkbox is never going to
3 be the answer to that.

4 Where nursing used to do most of it,
5 because the electronic health record found a way
6 to put the boxes in the screen, it became
7 medicine's problem. Bu the focus of where the
8 issues are, hasn't changed.

9 CO-CHAIR CANTRILL: Good point.
10 Arjun?

11 MEMBER VENKATESH: So I think
12 medication reconciliation, like you were just
13 saying there, it's a problem at multiple points
14 within the system. And just because the ED
15 happens to be an inflection point where we see
16 it, doesn't mean that that's where the quality
17 gap is.

18 And so I would ask people to help me
19 think here about what are the clinical scenarios
20 or the quality gaps with respect to medication
21 reconciliation. Or prescribing in the care
22 transition function of the emergency department.

1 And that makes it's -- and that's
2 hard. Because when we're discussing this
3 yesterday, the vast majority of prescriptions
4 from the emergency department setting are going
5 to be less than ten days.

6 And so their whole concept of how that
7 fits into the broader medication reconciliation
8 and safety picture is pretty limited. And so, we
9 have tried to develop measures in the past.

10 And I think there will be a place for
11 measures around safe prescribing in the emergency
12 department. So particularly use of
13 benzodiazepines, opiates, a lot of high risk
14 medications in the elderly, things like that.

15 That's not necessarily in and of
16 itself a care transition quality problem. That's
17 an emergency department safe prescribing issue.

18 There are probably some medication
19 prescribing relation ways to drug interaction
20 maybe that maybe valuable quality gaps. But I
21 don't -- we haven't heard of many in the past.

22 And so I'm interested to know, and

1 maybe Marc, you know some. I don't know like
2 where are the quality gaps of the transition for
3 a patient out of the ED to the next provider,
4 where the prescribing of medications or change in
5 medication results in a quality failure?

6 And I know there's some But I guess
7 I'm trying to get my head around where those
8 measures would be.

9 CO-CHAIR CANTRILL: Stephanie?

10 MEMBER WITWER: One example and that
11 we deal with on a regular basis, a patient comes
12 to the ED with atrial fib. And ends up being
13 prescribed some sort of anticoagulation, be it
14 short term, that would lead to long term. But
15 they're not connected to the anticoagulation
16 process that happens in the community.

17 So, that's one that comes to mind on
18 a fairly frequent basis.

19 CO-CHAIR CANTRILL: Brenda?

20 MEMBER SCHMITTHENNER: This is not a
21 reconciliation issue as well. But it is a major
22 issue. And that is that patients are prescribed

1 medications that they can't afford or they can't
2 access.

3 And so understanding their ability to
4 actually obtain those medications is really
5 important.

6 CO-CHAIR CANTRILL: Nicki?

7 MEMBER HASTINGS: Related to
8 medication reconciliation, some of the problems
9 that we've seen is when the prescribing emergency
10 provider does not know what the patient is taking
11 before they make their selection.

12 You can end up with therapeutic
13 duplications, number one. If you don't even know
14 someone's taking it. Or certainly drug/drug
15 interactions or drug/disease interactions can be
16 a problem.

17 And then on the other side of the
18 transition, if the outpatient provider doesn't
19 understand what has been prescribed, they might
20 not take the proper precautions. For us this
21 comes up a lot with patient who are taking
22 warfarin.

1 And even short term prescriptions for
2 antibiotics can have major impacts in relatively
3 short order if they don't get plugged back into
4 the anticoagulation clinic or whatever mechanism
5 for monitoring. Those are just a couple of the
6 bigger bucket ones we see related to transitions.

7 CO-CHAIR CANTRILL: Marc?

8 MEMBER PRICE: So to Arjun's point,
9 and what Nicki was saying, to sort of add onto
10 that also. The biggest thing that goes back to
11 that communication thing, when people come out
12 and they have a drug that's been prescribed
13 that's you know, meant to replace a drug that
14 they were on, they are not sure what' they're
15 supposed to be taking.

16 They either take the same, well both
17 drugs. Or they take the old drug and not the new
18 drug. Or they take the new drug, but they only
19 take it for the seven days that the ER happened
20 to give them. And it's supposed to be a long
21 term thing. And they don't understand how
22 they're supposed to take it.

1 So, it comes back to that education
2 and the communication with the patient.

3 CO-CHAIR CANTRILL: Karin?

4 MEMBER RHODES: So, I share the
5 concern of sort of check the box that reconciled
6 the medications. Which, you have to do to
7 discharge the patient.

8 And I don't think that's quality. And
9 so just acknowledging that up front.

10 It makes sense to say the emergency
11 physician should do reconciliation around new
12 medications that are prescribed. But the actual
13 reconciliation should fall back to -- it should
14 be a shared responsibility with the primary care
15 provider within a short period of follow up when
16 you've prescribed higher risk medications like
17 antibiotics when maybe they didn't bring the
18 shoebox to the ED and we don't know what they're
19 on. Things like that.

20 So, I would just acknowledge that we
21 can only really answer for what we do in the ED.
22 We want to make sure we're not giving an NSID if

1 they have renal failure or whatever.

2 But not beyond that. I would have
3 almost all the med reconciliation actually go
4 back to the primary care provider as a -- and our
5 responsibility is to communicate what we did.

6 CO-CHAIR CANTRILL: Julie?

7 MEMBER MASSEY: I want to echo some of
8 what you're sharing. I think another step that
9 we forget, I know we're primarily talking about
10 our treat and release and transferring back to
11 our community.

12 But I often think of medication
13 reconciliation, there's two steps. There's the
14 collection of an accurate medication history.
15 And that is something that I really struggle,
16 that I know the ED struggles with in an acute
17 emergency. And especially if you have a critical
18 patient.

19 But often that's the only place the
20 shoebox has actually appeared. And it's often
21 gone for our admitted patients by the time
22 they're actually doing the formal reconciliation

1 for that continuing of care. And they maybe
2 missing a piece of that information.

3 So if we think about our emergency
4 department patients, the collection of that
5 history as accurately as we can, as being a key
6 step that sort of paves the way for any
7 reconciliation. Whether that's the outpatient
8 when they go back to their primary care provider,
9 or the inpatient team who may not have access to
10 all the information.

11 Or that the list or the box, or the
12 care giver who's now gone home because they're
13 exhausted, and nobody else has the most accurate
14 historical information that impacts med rec down
15 the line, both the admission and the final
16 discharge. Because no one knew what the patient
17 started on after even an inpatient stay.

18 CO-CHAIR CANTRILL: Brenda?

19 MEMBER SCHMITTHENNER: I think one
20 question that is not necessarily asked, that is
21 an important one, is asking the patient, how are
22 you taking the medication?

1 You know, the fact that they have this
2 medication, the fact that it's been prescribed
3 for three times a day, the question needs to be
4 asked, well how are you taking this medication?
5 When are you taking this medication.

6 CO-CHAIR CANTRILL: Marcia?

7 DR. WILSON: Okay So we had under
8 measure concepts, this -- we had a good
9 discussion about provider experience.

10 And what we're talking about here is,
11 what is the provider's experience in the
12 transition of care? And it came up largely in
13 information.

14 And we talked about the information or
15 lack of information, the quality of the
16 information that the provider receives, is it
17 sufficient? Thinking about, there could be
18 information, there's obviously information coming
19 into the emergency department physician.

20 And then there is typically often
21 another provider in setting C. Not always, but
22 typically.

1 And so, we were intrigued with this
2 idea is that could we gather patient -- provider
3 experience information, patient experience about
4 the information received? And if that was done
5 even at an organizational level, is that
6 information that then could be fed back?

7 And we focused on say, transfers from
8 skilled nursing facilities to the emergency
9 department. Typically the patient goes back to
10 the skilled nursing facility.

11 If provider experience was,
12 information was collected about the quality of
13 the information or issues surrounding that
14 transition, could that become a feedback loop to
15 improve and/or enhance the care between the
16 skilled nursing facility and the emergency
17 department?

18 But also help the emergency department
19 understand some of the limitations of the
20 settings to which the patient is going back.
21 Because we did hear conversations where not all
22 facilities are created equal.

1 And the emergency department might be
2 thinking something is going to happen when the
3 patient goes to the next setting. And that
4 setting does not have the capacity or
5 infrastructure.

6 Follow up visits from the safety
7 outcomes subdomain. This is where we moved it
8 into concept.

9 Which is the recommendation for the
10 follow up visit, we had the same discussion that
11 you all have been having. When is follow up care
12 rec -- when should follow up care be recommended?

13 Now that's not really in our job jar.
14 Because we're outcomes. But the second setting
15 question is. Did the follow up actually occur?

16 So there's a process here. What was
17 recommended. There's a level of patient
18 understanding of what should happen. And then
19 there's an ultimate question as an outcome, is
20 did the appropriate follow up care happen? Next
21 slide.

22 Okay. We had some gaps. We realized

1 in our outcomes that we had not really addressed
2 shared accountability. So we will talk about
3 this this morning. Does that belong in the
4 outcomes domain? And how would we address it?

5 One comment I just wanted to capture
6 so we didn't lose it, was underutilization and
7 costs. Someone from an earlier conversation when
8 we talked about this domain said, what about cost
9 related to -- utilization and cost of community
10 services? We had been thinking very healthcare
11 focused.

12 Patient experience needs to be
13 expanded. That it is not only your experience in
14 -- within the transition. But that broader
15 patient reported outcomes of functional status.
16 So, where does that fit in?

17 And then these transitions, I think
18 we're going to turf to other people. I think
19 we've -- now that we've heard things, I think
20 we can turf these out.

21 And this really came up from Brendan,
22 where he was identifying this as a gap. And I'd

1 like to kind of expand on what he said.

2 Was, his concern was he was seeing as
3 a gap, certain populations arriving in the ED
4 when you don't have a lot of information. In
5 this project, that's not what we think of as a
6 gap. But it is clearly an area where the setting
7 B, that emergency department, is not getting the
8 information they need to make good decisions.

9 So, I don't think that is an outcome.
10 I do think it's an areas that we don't want to
11 miss when we're putting together this framework
12 and gathering the thoughts from this group.

13 So, I don't think that belongs in
14 outcomes. But we don't want to lose that
15 thought. And I think that was it. Questions?

16 CO-CHAIR CANTRILL: Amy?

17 MEMBER STARMER: I'll just build a
18 little bit up on my prior comment about the med
19 rec and thinking about medication related adverse
20 events. And I think you could expand that as
21 well.

22 I don't know to what extent you were

1 talking through transition related adverse events
2 or medical errors. Because I think things like,
3 you know, delays in care, redundancies of care,
4 and other types of outcomes beyond just
5 medications would be worth fleshing out probably.

6 DR. WILSON: Thank you. Okay. Ready
7 to?

8 CO-CHAIR CANTRILL: Yes.

9 DR. WILSON: Okay. So we're running
10 just a little bit later than we wanted. But we
11 did not -- we did not want to short-change that
12 conversation.

13 Because I think it helped. And I hope
14 it will help you as you go to your breakout
15 groups.

16 So, we appreciate your flexibility.
17 I will say, when I worked in San Diego, there was
18 a large Marine Corps base to the north of San
19 Diego in Oceanside. A huge Marine Corps facility
20 up there.

21 So you saw a lot of license plates
22 that said semper fi, the Marine Corps motto,

1 which is always faithful. And when I went to
2 work in healthcare at one point in time in San
3 Diego, they said their motto wasn't semper fi, it
4 was semper gumby, which meant always flexible.

5 So, semper gumby to you ED transition
6 expert panel. We appreciate your being flexible.

7 So, for breakout number three, here's
8 what we're going to do. We're going to send you
9 back with these slides to your breakout sessions.

10 And I'm going to give you three C's.
11 The first is clarity. Especially with your
12 domains, will others under that measure concept?
13 Is it going to make sense to others?

14 And also, is it in the purview of your
15 domain and/or subdomain? Now that we've kind of
16 talked about how like follow up and perhaps
17 shared accountability can live in multiple
18 domains, does that concept capture what your
19 domain is all about?

20 The second C is clean up. It's time
21 to weed the garden.

22 There were a lot of great ideas that

1 came out of the breakout sessions yesterday
2 afternoon. Now in the harsh light of daylight,
3 do you still love them as much as you did
4 yesterday afternoon?

5 And if not, it's time to let them go.
6 And to get to a more parsimonious set of
7 concepts, let's be realistic about what we can
8 achieve or what our focus is here.

9 And then the third thing is, with the
10 concepts, if a concept isn't clear, I would say
11 look at that concept and see if you can give it a
12 little more definition. Who is the target
13 population?

14 What would your denominator be?
15 Because a concept may sound good, but how would
16 you make that real?

17 If you had a -- were sitting with a
18 measure developer and they said, I've got the
19 money, I will develop this concept, what would
20 you say to that measure developer to help them
21 understand the parameters of that concept?

22 And I also think by doing that you get

1 back to that first C, which is clarity. We get
2 greater clarity about the concepts.

3 So that's -- I'm looking at my team
4 colleagues. That's our plan for what we want you
5 to accomplish in your breakout sessions this
6 morning.

7 I think we're just going to move
8 straight into the sessions. And why don't we
9 reconvene at 11:15. Does that sound reasonable?

10 So 11:15 we'll be back in here. We'll
11 do a brief report out. And were how we did in
12 cleaning up some of our work from yesterday.
13 Thank you.

14 CO-CHAIR CANTRILL: And we'll be in
15 the same areas. Yes.

16 (Whereupon, the above-entitled matter
17 went off the record at 10:01 a.m. and
18 resumed at 11:23 a.m.)

19 DR. WILSON: Okay, I think we'll
20 reconvene and get started. And what we're going
21 to do is just very brief, very brief report-backs
22 from the group. And what we'd like is just a

1 fairly high level summary of after this morning's
2 conversation we kind of grounded everyone at what
3 was going on across the domains. Some of you got
4 feedback directly on either concepts or measures
5 that you had in your domains.

6 So a high level of kind of how your
7 conversation went, how, what kind of progress you
8 made. If you have one example or two examples of
9 either concepts that you deleted and why, or a
10 concept that you kind of speced out, fleshed out
11 a little bit more, that would be helpful. But
12 we're just going to do a few minutes on each
13 subdomain so that we're ready to break for lunch
14 about noon.

15 So, Jesse, you want to lead us off,
16 please.

17 DR. PINES: Sure. So we had I think
18 a great discussion. Some of the sort of big
19 changes -- and actually this sort of follows on
20 the discussion of medication reconciliation this
21 morning -- would be to, you know, really sort of
22 the central pieces is defining high-risk

1 transition. And we thought that emergency
2 departments and, you know, it would be much
3 better to sort of focus on these high-risk
4 transitions much more than sort of every single
5 transition.

6 And we thought that when it came to
7 medication reconciliation, high-risk prescribing
8 is one of those high-risk transitions that should
9 be -- that would potentially have a checklist.

10 We also talked a little bit about the
11 receiving the ED discharge summary and how that,
12 we think, for these high-risk discharges that
13 that should be within 24 hours, but not
14 necessarily for all ED visits.

15 And then there should be, we talked a
16 lot about sort of follow-up and when that should
17 happen. But and I think that sort of, you know,
18 thinking of the concept to follow up and, you
19 know, sort of more broadly in terms of sort of
20 checking in on someone after one of these high-
21 risk discharges by either, you know, by either
22 primary care. Ideally this would be a primary

1 care physician primarily for community-dwelling
2 adults without, you know, sort of pulling out the
3 people in long-term care facilities. But within
4 72 hours there would be some sort of check-in.
5 And that check-in could either be an in-person
6 visit, phone, email, some sort of connection for
7 that with the patient.

8 Marc brought up the need for with
9 additional action, you know, required actions
10 would have to be additional payments or other
11 sort of codes that could be used for those sorts
12 of decisions.

13 We talked about, a little bit about
14 sort of how the sort of feedback system could
15 work. So we talked about sort of developing a,
16 you know, sort of some sort of structural measure
17 around sort of the electronic communication of
18 the care plan and sort of how that, and sort of
19 how that would be decided upon and sort of
20 mutually agreed upon collaboratively between the
21 emergency department and the PMD.

22 We also talked about a potential

1 structural measure of EHR quality that actually
2 does fall under the purview of some of the other
3 work that's going on in NQF around
4 interoperability. But, you know, some sort of a
5 system that could identify specific cases for
6 feedback for learning purposes.

7 We did discuss the idea of this
8 taxonomy that we think, and the definition of
9 high risk which we think would be a great sort of
10 future development project, specifically defining
11 high risk and guided by specific clinical
12 symptoms and different clinical scenarios.

13 We also talked a fair amount about EMS
14 and sort of the role of EMS measures.

15 We talked the accessibility of pre-
16 hospital data within the EHR. It's a good
17 measure.

18 We thought some of the disease-
19 specific EMS measures were a little bit out of
20 scope but are potentially good measures,
21 specifically around STEMI and LVO.

22 We did a little bit, we talked a

1 little bit about the terminal -- transferring
2 terminally ill patients and visiting
3 specifications a little more, sort of detail,
4 sort of wordsmithing around that.

5 And then for the issue around
6 identifying social determinants in the ED and
7 making sure that information is sort of
8 identified in the ED, we're actually moving that
9 out of our group into Community Engagement. So
10 the Community Engagement group we think would be
11 better qualified to take a look at that measure.

12 However, we did come up with a new
13 measure around sort of a more general measure
14 around EMS around PCP notification for high-risk
15 health events that are not transferred. So
16 someone falls down and they, you know, are put
17 back in bed. So that information should get back
18 to the primary care physician. Although it's a
19 bit out of scope because right now we're focusing
20 on the emergency department.

21 And we also talked a little bit about
22 the, you know, needs specifically around EMS,

1 around sort of defining an EMS quality transition
2 from EMS, and what are those, what are those data
3 elements for a high-risk for an EMS transmission.

4 And then, finally, we had a discussion
5 a little bit about sort of accuracy and how that
6 would work. And we thought that the two ideas
7 that came up would be sort of a structural
8 measure around a QA process that could really
9 sort of look at the details of these transitions
10 and make sure that there was a QA process or some
11 sort of system in place to actually, you know,
12 look at transitions, or alternatively, provider
13 experience surveys.

14 CO-CHAIR CANTRILL: Any questions or
15 comments for Jesse? Jim.

16 MEMBER DUNFORD: Did you guys think
17 about feedback to EMS? Some of these new systems
18 that are being tested now actually provide, you
19 know, outcome back to the EMS provider as a
20 measure of, you know, kind of closing the loop.

21 The other thing was had you guys
22 thought about the possibility of measuring the

1 wall time, ambulance transfer time?

2 So that was one of the things we were
3 going to pass back to your committee.

4 (Laughter.)

5 MEMBER DUNFORD: We had a kind of a
6 broader scope. We also thought that the time to
7 hand off, for example, of a law enforcement
8 officer who's got an involuntary psych patient on
9 hold, that there could be a process to measure
10 there, or anybody else that was being brought in.
11 I can't think of the other scenarios. But any
12 kind of individual being brought in, if the
13 timeliness of the transfer of responsibility was
14 an idea we thought, we thought you guys are much
15 better at that.

16 CO-CHAIR CANTRILL: Turnabout is fair
17 play.

18 Any other comments?

19 (No response.)

20 CO-CHAIR CANTRILL: Moving on to
21 patient communication. Kyle.

22 MS. COBB: I tried to pass this off

1 onto Donna, but she refused. So she's going to
2 tag team with me, I hope -- as I look up at the
3 ceiling. Not that that's where you are, Donna.

4 So, the Patient and Care Communication
5 group certainly did recategorize and make some
6 changes. And we do have unresolved issues. So I
7 will start at a high level.

8 Our conversation has revolved over the
9 last two days around how that patient
10 communication is different, and if it's
11 different, and why it might be different. And we
12 keep going back to is this different than the
13 information that's being used in a provider
14 communication domain, and should it be?

15 And when we talked about things being
16 fluid we get sort of caught up in how that may be
17 the same or not, and things like modalities. But
18 what we do know is that it is unique insofar as
19 the patient communication spans across all of
20 these domains. And it is central to really
21 everything that we're doing.

22 So I will -- sort of that is the

1 really high level part of the conversation. And,
2 Donna, please chime in.

3 MEMBER CARDEN: Okay. So, thank you,
4 Kyle.

5 And I will just, again this is a
6 summary over our, of our conversations over the
7 past couple days as well as the broader group
8 discussion. But I'll tee off of what Kyle just
9 said. And that is that we really felt that the,
10 all of the other groups revolve around an episode
11 of a care that's initiated for the most part by
12 the patient. So, we took a very patient-centric
13 approach to this provider-patient/carers
14 communication.

15 And there are two key aspects that we
16 at the end of the day felt were incredibly
17 important and that dictated the success of the
18 transition and really dictated the conversations
19 that involved the other groups. And that is the
20 ability of the patient or carer and the provider
21 in the emergency department to quickly -- because
22 it's a time-sensitive environment -- get at the

1 essence of what is the patient, what is their
2 health crisis. Assessing those concerns of the
3 patient from the patient's perspective. And that
4 has to be done in the time-sensitive and quick
5 environment.

6 But if it's not done accurately, then
7 chances are that transition is going to be a
8 failure. So assessing that health concern of the
9 patient is probably first and foremost in terms
10 of the communication that needs to be measured or
11 accurately recorded.

12 The second thing -- and this was
13 brought up repeatedly in our discussions
14 yesterday, as well as I heard it in the broader
15 group discussion this morning -- and that is some
16 sort of a confirmation of the patient's
17 understanding of what happens in the emergency
18 department.

19 We took that one step further and we
20 turned that into something that we hope will be
21 measurable, which is the evolving role of shared
22 decision making. And that is reflecting back to

1 the patient, what their concerns are, and then
2 from the provider's perspective what should
3 happen next. But that is shared decision making
4 with the patient that takes into account their
5 literacy, cultural competency, their patient
6 preferences, their social determinants.

7 Because if those factors are not in
8 that shared decision making, then chances are you
9 can prescribe whatever you want. You can say
10 whatever you want. You can have just a
11 transition record that has whatever you want.
12 But if the patient doesn't understand it or
13 doesn't agree with it, that is not going to
14 happen, and that may well be a failed transition.
15 The patient may come back to your emergency
16 department or to another one.

17 And so really there are evolving
18 measures around shared decision making that are
19 out there. We looked at some of the CAHPS
20 questions, HCAHPS questions on provider
21 communication such as did the provider listen
22 carefully to you? Did they address your

1 concerns? Did they explain these medicines in a
2 way that was easy for you to understand? This is
3 the essence, this is the spirit of what we
4 believe is critical to a successful transition
5 for the treat-and-release emergency department
6 patient. This isn't the gunshot wound to the
7 chest. This is the common treat-and-release
8 emergency department patient.

9 And, also, it acknowledges the fact
10 that that treat-and-release ED patient is likely
11 more complex, has less social resources,
12 neighborhood resources, than does a patient who
13 presents to an ambulatory care setting.

14 And so we feel that, you know, there
15 are certainly gaps in measures. But after much
16 discussion and sort of angst and hand-ringing we
17 really believe that the essence of what we need
18 to capture is: was the patient's concerns
19 assessed, and did we address them in the
20 emergency department in a way that was respectful
21 of shared decision making and that was
22 understandable, actionable, and usable by the

1 patient?

2 MS. COBB: Donna, everybody's nodding
3 their heads. So just so you can get that
4 feedback.

5 MEMBER CARDEN: Okay, thank you.

6 MS. COBB: And I'll just say Amen.

7 Well put. And I think, you know, I
8 would just add nothing.

9 CO-CHAIR CANTRILL: Okay. Any
10 questions or comments concerning patient
11 communication? Jim.

12 MEMBER DUNFORD: My experience with
13 elderly people is that 99.9 percent want to go
14 home. And so when we ask people what do they
15 want to do, a lot of the framework and analysis
16 that we've been doing here really isn't taking
17 into account the possibility that the patient
18 could be admitted to home.

19 I really do think that's where
20 emergency medicine is going to be moving. And I
21 think we have to be very cognizant of that, that
22 as step one is being accomplished, we're

1 assessing the condition and determining what's
2 needed. Simultaneously parallel processing
3 should be what's an analysis of the stability of
4 the home and the social circumstances that will
5 allow that patient to go home and get these very
6 same intravenous antibiotics or whatever.

7 So I think, you know, I don't want to
8 operate in too traditional of an emergency
9 department world here because the ED of the
10 future is going to be quite different in ten
11 years. In two years.

12 MEMBER CARDEN: And I agree. And I
13 think this may be where we bridge with our
14 community resources.

15 MEMBER DUNFORD: I think the obser --
16 we haven't really talked much about observation
17 medicine. But really the obstetrics area is the
18 place to kind of sort a lot of that stuff out if
19 it can't be done in the ED. And that is very
20 much a thing that's coming quickly as well.

21 CO-CHAIR CANTRILL: Elif.

22 MEMBER OKER: So to that point I'm

1 just feeling that an under-utilized resource in
2 terms of accessing what's available to that
3 patient is their payer. Many, many people have
4 care management, disease management, social
5 services, and all kinds of other services
6 available to them through their payer. And those
7 are often nurses, social workers. That is one
8 area that could be accessed and you can offload a
9 lot of that planning and a lot of the care
10 coordination and financial decision making to
11 that resource.

12 But I'm not hearing that come up much.
13 So, just putting it out there.

14 CO-CHAIR CANTRILL: Good. Thank you.
15 Any other questions or comments about this
16 domain?

17 (No response.)

18 CO-CHAIR CANTRILL: Engagement of
19 broader community. Kristin.

20 MEMBER MASSEY: Unfortunately --

21 CO-CHAIR CANTRILL: Sorry, Julie.

22 MEMBER MASSEY: -- our spokesperson

1 isn't here.

2 But I think two things I mentioned
3 before I took the mike. It came up, the concept
4 of engaging the payer as part of that broader
5 community. I have a lot more information. We're
6 focused in more accountable care type settings
7 where they're actually -- and one of the limited
8 infrastructure that we know exists in the
9 community and community resources that the payer
10 may actually have access to more of that, be able
11 to communicate that more.

12 One resource, and it's one of the CMMI
13 Accountable Community demonstration that is just
14 starting to take off was mentioned, as we should
15 look there to some of the resources to assess
16 community needs. There are some metrics. There
17 are some things that they're testing. And as we
18 go to inform, we really made a major shift from
19 yesterday to today. I think we initially thought
20 we could engage the ED in making and completing a
21 lot of these community referrals and recognize
22 that's really burdensome for the emergency

1 department.

2 It's also challenging in a 24/7
3 environment when the community services really
4 may not be prepared to receive that in a 24/7 way
5 and that. So we reshifted sort of our focus on
6 what we would be looking for, for to providing
7 the information and to seeing how we do that.

8 And I will say we kept coming back to
9 one of the key elements is to try to add to every
10 measure of a summary of care an element of the
11 care plan and an element of the community follow-
12 up plan. So that as key elements that we need to
13 engage our patient to be the carrier and sort of
14 who's going to execute this recommendation or
15 referral, because we really can't rely yet --
16 although it's aspirational --on the ED making
17 that direct referral to the community services.

18 But if we're making it, and it echoes
19 a lot of our heads nodding, of the patient and
20 their role in understanding that next step has to
21 be in the patient communication and in the
22 provider back to the primary care who can

1 reinforce and to help connect some of those
2 services. That we have to leverage our existing
3 summary of care documents to include that
4 information.

5 We did look at a couple of measures,
6 some process structure and an outcomes measure.
7 Structurally, one of the first key elements that
8 we thought was really important to figure in a
9 yes/no, is does the ED and the facility have a
10 process in place to ensure collection of a
11 resource list and availability and access of that
12 list in the ED? We recognize on the inpatient
13 side that's often collection, may even be
14 available on an internet or a web, but that it's
15 not always accessed.

16 And I think the second structural
17 measure that we proposed was looking at whether
18 there are care management or navigator services
19 in the emergency department. Because it's not a
20 physician, it may not be nursing in that
21 emergency setting who's going to access this
22 resource list. But do you have the services and

1 some of the measures we looked at that, one was a
2 yes/no. Do you have a process in place to
3 collect and maintain?

4 And the second piece was sort of what
5 percentage of your ED hours, what times during
6 the day, if you have them, do you have the care
7 management navigator resources available, even if
8 it's connecting -- they're often the ones that
9 are connecting back to the payers for that just
10 for payment purposes. But are we looking at are
11 community resources available?

12 The second piece we really worked to
13 try to look at is the assessment piece. How do
14 we know our patients are at high risk of a
15 transition failure if we don't assess them? So
16 using -- we recognize that there are some
17 standardized tools. But we need to collect, to
18 assess. And we tried to define the population
19 that we were going to assess because we also
20 recognized that it would be burdensome to assess
21 every patient who comes to the door.

22 We recognized our vulnerable

1 populations in the under 18 and over 65 that we
2 said with one chronic condition, everyone should
3 be assessed. And in that in-between, if they had
4 more than one chronic condition, something on
5 their problem list, that they should at least be
6 assessed for unmet social needs. That had to be
7 coupled with having an available resource list
8 that could be accessed, and someone who could
9 access it to provide that recommended follow-up.

10 So we talked about the populations to
11 screen. We talked about the screening process.

12 And then the last one we looked at was
13 outcomes, to try to look again, capturing
14 revisits as it's a bigger umbrella picture.
15 Revisits due to a transition failure, due to the
16 unmet social needs that had been previously
17 identified. So, this we felt was more of an
18 ability to inform communities' needs. If we
19 found X number of patients, and I think the
20 example we kept coming back to, X number of
21 patients who might have had a need-related or
22 failure due to a need for a resource in the

1 community that didn't exist.

2 And if we can standardize how this
3 revisit is collected and captured, that we were
4 better able to assist community needs across
5 hospitals, and then have a potential to actually
6 fill the community needs if we could actually
7 assess it.

8 CO-CHAIR CANTRILL: Thanks, Julie.

9 Any questions or comments? Joe.

10 MEMBER KARAN: Our whole foundation is
11 built around community needs and community
12 resources. And it takes a little bit of digging
13 but they all exist out there, regardless of where
14 you're living. And those lists are usually
15 anywhere from 20 to 30 lines long with different
16 community services.

17 One of the problems that we do have is
18 that there's so many different payer programs,
19 that to have that list and assume it doesn't
20 change, which it does, but to have that list is
21 fairly simple to find. And it could be done when
22 the first transmission to the payer is made for

1 the patient. You know, what services do you have
2 for this patient under their policy?

3 MEMBER MASSEY: To that end, the other
4 thing that we initially had yesterday, we talked
5 a lot about collection of care team and patient
6 consent for communication. We're relying on the
7 patient and that summary of care document to
8 transfer the information. But part of this
9 assessment of needs has to also recognize what
10 they may potentially either be eligible or
11 enrolled for, so that we can make the
12 communication to the Meals on Wheels that they're
13 in the hospital, but then equally reconnect when
14 they're leaving, if there are those kinds of
15 needs.

16 But understanding what's available to
17 the patient was part of what we were thinking
18 that assessment had to accomplishment.

19 And we recognize the care team
20 collection is critical, but we also realize
21 that's part of the provider and part of the
22 patient communications to make sure that we're

1 collecting it, but relying on the patient to be
2 the conduit to some of these other community
3 services.

4 CO-CHAIR CANTRILL: Thank you, Julie.

5 Any other questions of comments
6 concerning this?

7 (No response.)

8 CO-CHAIR CANTRILL: We'll move on to
9 our final domain, achievement of outcomes.
10 Marcia.

11 DR. WILSON: Okay. Thank you, Steve.

12 Hearing a lot of common themes here.
13 So when we went back, a couple of things
14 happened. One, we started to flesh out
15 medication reconciliation, looking at more
16 specifications. And one of the themes that we're
17 picking up on is this need to identify high-risk
18 patients. We don't want these global measures
19 where everything is done to every patient.
20 Somehow there's got to be a stratification or
21 acknowledgment that, while medication
22 reconciliation is such a critical issue,

1 depending on the patient, depending on the
2 transition it can take different forms or be in
3 different levels so to speak.

4 We looked at, also, outcomes. And,
5 Amy, thank you very much for your comment because
6 you really got us thinking about a lot of
7 different kinds of outcomes that we haven't
8 focused on: adverse drug events, medical errors.
9 So I think that we have now a number of concepts
10 that we can pursue there that I think will be
11 very worthwhile.

12 And then when we went back to follow-
13 up in this paired measure up, there's a
14 recommendation made for follow-up, which is a
15 process measure. The outcome measure is Did the
16 follow-up happen? And we really struggled with
17 this in terms of shared accountability. And we
18 had this great philosophical discussion of who
19 can be held accountable for what.

20 And I will tell you, at National
21 Quality Forum we have that at every committee
22 meeting that we ever have. It's very much coming

1 up.

2 But if we go back to this shared
3 accountability, this implied system of care,
4 which is where we are moving, we looked at what
5 would be aspirational, which is perhaps return
6 visits to the ED, knowing you would never want to
7 hit an absolute number there. It would be some
8 kind of -- there would be -- it would never be a
9 zero, it would never be 100, and allowing for
10 that. But we talked about the difficulty of
11 finding out how that, why that patient, when and
12 how that patient comes back to the ED.

13 But we think aspirationally that's
14 where we need to go to that system of care with
15 information from the ED, with information from
16 the other setting of care. And so we're going to
17 work on that one, which we acknowledge may not
18 happen in our lifetime. But we're going to look
19 at other intermediate outcomes that would move us
20 towards that.

21 We talked about the financial
22 incentives or reimbursement. And, Arjun, to your

1 point, let's not build for the fee-for-service
2 environment. Thank you very much. And that will
3 probably come up this afternoon when we do our
4 recommendations discussion of some of the
5 reimbursement issues, acknowledging that if
6 there's going to be a higher touch with that
7 patient, by whatever modality, there needs to be
8 the incentive to allow that to happen. So, keep
9 that in mind when we talk about recommendations.

10 So, Steve, anything else that we
11 missed? Arjun?

12 MEMBER VENKATESH: I was just going to
13 add that, you know, I think that maybe the
14 framework that we can put out there when it comes
15 to outcomes measurement that would be an
16 advancement is a lot of the measures right now
17 that measure the ED visiting outcome, the thing
18 that's frustrating about it is it makes any ED
19 visit an adverse outcome.

20 DR. WILSON: Right.

21 MEMBER VENKATESH: And I think there's
22 a general understanding and expectation here that

1 there is a lot of acute injury and illness that's
2 going to require an indexed emergency department
3 visitation, and even additional emergency
4 department visitation.

5 What we're trying to capture is ED
6 visitation that is occurring as an outcome of
7 poor care coordination.

8 DR. WILSON: Yes.

9 MEMBER VENKATESH: And so, we've
10 developed a measure at Yale for hospital
11 discharges in which we try to measure the excess
12 days that are spent in an acute care setting
13 after a hospital discharge.

14 And so the idea, though, behind this measure
15 is with the risk-adjusted model is trying to set
16 up a world in which you say there is an expected
17 number of acute care days that a patient may
18 require after a hospital discharge. They may
19 require some amount of days in a hospital in the
20 emergency department in the observation setting,
21 but that there's an excess amongst what would be
22 predicted in the model that would be potentially

1 a signal for care coordination.

2 I think that that approach could work
3 in this world. And the reason it would be good
4 for our group to say that that's the kind of idea
5 we're trying to get at is it puts out this idea
6 that there is an expected number of acute care
7 days or emergency department visits that might be
8 anticipated amongst a population of patients that
9 have multiple chronic conditions. But it's the
10 excess ED visits beyond that that we are trying
11 to measure as a potential signal of poor care
12 coordination.

13 And so, if that's something that
14 resonates with folks, I think that that's the
15 type of thing that might make sense.

16 CO-CHAIR CANTRILL: Absolutely, Arjun.
17 I think we discussed that but not in that degree
18 of elegance in terms of terminology. Because
19 there are an expected number of people that you
20 do want to have come back. And I think that's an
21 excellent way to put it. And I think if we put
22 that forward, that's a very nice generalized

1 approach to get away from the fact that any
2 return ED visit is a bad visit.

3 DR. WILSON: Yes.

4 CO-CHAIR CANTRILL: So, and I think
5 that's something that would be very worthwhile to
6 put forward.

7 DR. WILSON: Yes. And the NQF team
8 has been talking about that. We want to be very
9 clear in our language that it is appropriate in
10 some cases for that patient to come back to the
11 ED. So we want to be very careful that we're not
12 couching in the terms of we're trying to
13 eliminate or reduce ED visits, but where it's
14 appropriate and where it might be expected, those
15 visits where the patient is coming back because
16 the transitioning care failed in some way, those
17 are the ones that we want to find and fix.

18 So it's a great distinction. And the
19 NQF team is very sensitive to the language that
20 we're going to use.

21 CO-CHAIR CANTRILL: Thanks, Marcia.

22 Jim.

1 MEMBER DUNFORD: Totally agree with
2 that. Our group was also just sensitive to the
3 possibility that a single visit could constitute
4 a sentinel event that's going to predict a future
5 that could be a lot worse. And that was
6 basically the elderly fall victim who might have
7 just fallen for the first time, and whether or
8 not we'd actually intervene on that person to
9 prevent the hip fracture.

10 And so that's why we actually added
11 age under 65, all you need is just one chronic
12 condition in order to qualify for screening. So
13 just that thought of should the ED actually play
14 the role of, you know, saying, you know, with
15 great predictive likelihood this guy will fall a
16 second or third time. And he's going to cross --
17 you know, he'll never get back to normal again.

18 CO-CHAIR CANTRILL: Jesse.

19 DR. PINES: And I think this could be
20 a great outcome for specifically those high-risk
21 discharges and sort of defined by the, you know,
22 patients who don't have primary care physicians

1 versus those that do. Because, you know, I think
2 we still know that a third of the patients we see
3 are not going to have primary care physicians.
4 And that, you know, and like Arjun said, I think,
5 what, 80 percent of those when they tell us who
6 it is it's right, so 20 percent it's wrong.

7 So, so really sort of defining the,
8 you know, the population with whom, you know,
9 maybe the, you know, the specific instruction is
10 that if you are not able to get into a primary
11 care doctor within X amount of, you know, within
12 a week, your instruction is to come directly back
13 to the emergency department for additional care
14 coordination.

15 CO-CHAIR CANTRILL: Okay. Any other
16 comments or questions concerning that?

17 (No response.)

18 CO-CHAIR CANTRILL: Okay. Operator,
19 can you open the phone lines to see if we have
20 any questions or input from the listeners?

21 OPERATOR: Yes, sir.

22 At this time if you would like to make

1 a comment, please press star then the number one.

2 And there are no comments at this

3 time.

4 CO-CHAIR CANTRILL: Thank you,

5 Operator.

6 With that we will adjourn to lunch, a

7 short lunch. Pick up your lunch and come back.

8 Yeah, we're going to start at 12:15. So you can

9 eat at the table. It's accepted.

10 Have a nice lunch. Thanks.

11 (Whereupon, at 11:54 a.m., the panel
12 recessed for lunch, and reconvened at 12:17 p.m.)

13 CO-CHAIR NILES: Okay, let's go ahead
14 and get started. Before we get into our
15 discussion, Steve wanted to say a few words.

16 CO-CHAIR CANTRILL: Unfortunately, I
17 have to depart before our discussion will
18 probably be concluded this afternoon. And I just
19 wanted to express my thanks to you all for a lot
20 of very hard work and excellent thoughts and
21 ideas, and I think quite a profitable and
22 productive two days.

1 And also want to thank my co-chair
2 Janet, and Marcia and Kyle and Kirsten, and the
3 remainder of the NQF staff for an excellent
4 meeting. So thank you, and we'll be talking
5 soon.

6 CO-CHAIR NILES: All right, thank you.

7 So we're going to change the dialog a
8 little bit now and kind of lift up a little bit,
9 get out of the weeds a bit and away from the
10 measures a little, and we're going to talk about
11 what we need in the environment to be able to
12 effect the changes that we've just been talking
13 about all morning.

14 And if you think about if you've
15 listened to the report-outs from the different
16 groups, there are definitely themes that have
17 been emerging. I think you've heard them all:
18 communication, technology, there's all different
19 kinds of themes that have been emerging.

20 What we want to do now, if we could
21 have the next slide, what we want to do now is to
22 have a little discussion about what are these

1 overarching issues that we need to identify in
2 order to be able to effect these changes?

3 What needs to be standardized? I
4 think Arjun brought up some standardization
5 questions earlier. What do we need to do there?

6 What policy-level recommendations do
7 we need to be making to CMS, to the Hill, to the
8 private payers in order to make these things
9 happen?

10 What are the barriers that are in
11 place, and how can we solve problems to get
12 there? I think we had a little discussion this
13 morning about a national person identifier. You
14 know, that's a particular barrier, but how do we
15 make, get a solution to get there?

16 So, anyway, I want to open this up to
17 the committee for discussion and talking about,
18 you know, where we want to be? What does the
19 ideal state look like? And, Jim, I may pick on
20 you a little bit since California's going to be
21 there in, what did you say, a year or two? So,
22 so do you want to take it away a little bit?

1 MEMBER DUNFORD: Well, all right.
2 I'll just be aspirational.

3 To me, one of the biggest issues is
4 always the issue of privacy and the sharing of
5 information between healthcare space and the
6 community-based organizations. That's just such
7 a huge stumbling block. The lack of a common
8 consent to be able to share across those domains
9 just really impedes things. When you really
10 can't find out.

11 You have social workers going into
12 homes and yet you have no information oftentimes
13 that comes back to tell you what they found. And
14 you don't really know all the different
15 organizations. So, I would put in a broad
16 category to me the idea of privacy and kind of
17 overcoming that barrier of being able to have a
18 very inclusive care team where you can share
19 information.

20 Obviously it has to be done
21 strategically. But, you know, we're doing this
22 in San Diego. We have this, we have kind of a

1 pilot program where my paramedics share data with
2 housing providers. They share it with senior
3 care teams. And they even share it with Meals on
4 Wheels. A limited data set, but as I might have
5 mentioned to you earlier, when housing providers
6 know who's a super user in the city of San Diego
7 they make more -- they make better housing care
8 plans that result in more stable housing. Simply
9 the knowledge of who calls an ambulance 50 times
10 changes the way that they actually execute their
11 housing plans and results in more stable housing.

12 So this concept is, you know, of
13 sharing across the means and not telling, you
14 know, we're not going to inform on, you know,
15 he's got HIV and she's got this or that. That's
16 really not the information we're talking about.
17 But selective data that actually informs, to me
18 really is the heart and soul of the high-risk,
19 high-needs patient, that super vulnerable
20 individual that costs the most and, you know,
21 gets the least out of coming to the emergency
22 room.

1 CO-CHAIR NILES: Thank you. That's
2 very important information. I agree with that.

3 Anybody else want to throw out their
4 ideal situation and barriers that you've got to
5 getting there? Julie.

6 MEMBER MASSEY: You mentioned a
7 single-patient identifier. And we kind of all
8 know that. But I think understanding what that
9 means while balancing those privacy needs is
10 critical, and we understand that.

11 But there's --- it's very challenging
12 to try and engage any role of technology if we
13 can't identify the patient as the same patient.
14 And I know we hear it, we talk about it a lot.
15 But I think whatever that recommendation is it's
16 almost found -- it's foundational for some of the
17 other stuff we're trying to improve.

18 CO-CHAIR NILES: What about
19 regulations that stand in our way? I know
20 privacy is one that we've got a lot of
21 regulations around. But there are other areas
22 that we have regulation that impede our ability

1 to execute on our vision. Brenda?

2 MEMBER SCHMITTHENNER: The Bipartisan
3 Policy Center recently came out with some
4 recommendations where they identified very
5 specific barriers, either within Medicare
6 Advantage plans, ACO regulations, or even
7 legislation that were standing between accessing
8 effectively community-based services, and being
9 able to pay for those. Understanding that the
10 utilization of those services would likely reduce
11 healthcare costs and improve healthcare outcomes.

12 And I think that on a policy level we
13 need to really advocate for those policy changes,
14 those regulatory changes that would support the
15 ability to coordinate care better for really
16 high-risk individuals.

17 CO-CHAIR CANTRILL: Karin.

18 MEMBER RHODES: So, following up on
19 the prior comments, a universal health
20 information exchange to go along with that
21 personal I.D., with opt out, not opt in. I know
22 it's state by state and it's not well

1 operationalized in a lot of states, so being able
2 to really access records anywhere you go, any
3 provider, and that all records are sort of
4 feeding into that, so some sort of
5 interoperability that goes through the HIE.

6 And privacy concerns, perhaps you
7 could opt out of some aspect of it, but only with
8 the understanding that you might want someone to
9 break the glass if you were in an emergency, in
10 an accident and couldn't speak for yourself. But
11 opt out works very well.

12 And most patients, we did a survey,
13 most ER patients definitely want you to be able
14 to break the glass. Mostly they just want all
15 their providers to have their records, all of
16 their records. So I think it will have patient
17 support.

18 CO-CHAIR NILES: Aleesa.

19 MEMBER MOBLEY: Bouncing off of what
20 you just said with a universal data exchange, we
21 can make it a little more patient-friendly by
22 making the patient the owner of it. If we simply

1 had a universal repository where each patient
2 could upload whatever health data they wanted
3 into their space so that they could give access
4 to whoever they wanted to have it, even if it was
5 only temporary access.

6 CO-CHAIR NILES: Andrea.

7 MEMBER PEARSON: I think Aleesa, kind
8 of like my point, I think I agree with that we
9 need some sort of holistic access. I would
10 disagree with the fact that it should be opt out.
11 I don't see this ever going anywhere being
12 acceptable to a large swath of people if they had
13 to opt out. Personally, I wouldn't want to have
14 to opt out. I'd like to be able to choose who
15 can see things at any time.

16 I understand in an emergency that's
17 different, where I'm incapacitated, someone might
18 have to break the seal, but even then there
19 should be documentation and locks where they have
20 to say who they are, why they're accessing
21 things. I just feel very strongly that there is
22 -- you know, privacy is important, and I think if

1 people are going to sign up for patient
2 identifiers, if they're not guaranteed that they
3 can easily keep that, keep things private that
4 they want to keep private, they're not going to
5 sign up. And it can be pretty burdensome to go
6 in and try and opt out of things.

7 I mean, there's access issues. What
8 if you don't have a computer at home? What if
9 you -- you know, there's just there's too many
10 things to make that feasible for most people.

11 CO-CHAIR NILES: Karin, I'll let you
12 respond to that since that was yours.

13 MEMBER RHODES: So, the vast major --
14 people who when you have laws around opt in,
15 people have to make that decision. They're not
16 sure what it means. And you get very low rates
17 of participation.

18 When you do opt out you have very low
19 rates of people opting out. You have to make it
20 easy. But do you think that her solution of the
21 patient owning "I want to share with this
22 doctor," you know, "I want to make my records

1 available here but not here," would help solve
2 that problem? If it was -- because making it easy
3 for a person to own their own records and share
4 them?

5 MEMBER PEARSON: I mean I think if the
6 person owns their own records -- and maybe I'm
7 misunderstanding your point -- if the person owns
8 their own records and they're choosing who has
9 access to those records, that sounds like opt in
10 to me, not opt out. That is not, the default
11 isn't that anyone who I come into contact with
12 can access all of my records unless I say no.

13 MEMBER MOBLEY: That's correct. What
14 she --

15 MEMBER PEARSON: Sorry. Maybe I'm
16 misunderstanding what you're --

17 MEMBER MOBLEY: What she started with
18 was that umbrella of some repository. But when
19 she mentioned opt out, to me I had the same
20 feeling that you're expressing. That means
21 somebody else owns my data, which also means
22 somebody else might be able to sell it, show it

1 to somebody, share it with somebody.

2 So I took her point of view and then
3 I stretched it into, well, I should own the data.
4 I should decide what gets uploaded. I don't want
5 you to see my mammogram but I want you to see my
6 lumbar spine. Okay? Once it's there, it's in my
7 space. I still own that space. So there is no
8 opting in or out, it's just mine if I want to put
9 it there.

10 And then I get to allow whoever needs
11 to see it either forever or just for a temporary
12 amount of time.

13 MEMBER PEARSON: Right. And I guess,
14 yeah, that would be, that would be my definition
15 of opt out maybe. Maybe we're working on
16 different definitions. But I just, I just feel
17 strongly about there can't be a repository that I
18 -- that anyone can access unless I say you can't.

19 CO-CHAIR NILES: Definitely something
20 for more discussion.

21 I can't see your name down here but --
22 yeah, there we go. Okay.

1 MEMBER PRICE: So --

2 CO-CHAIR NILES: Oh, it's Marc. Okay.

3 I thought it, I thought it was -- Okay, go ahead.

4 MEMBER PRICE: I can be her if you
5 like.

6 CO-CHAIR NILES: No, no. Go right
7 ahead, Marc.

8 MEMBER PRICE: So, I had a couple
9 thoughts, just in your general comments as well
10 as the computer records.

11 My vision, which I actually shared
12 with John last night, is that I think there
13 should be like a medical internet where all the
14 data, no matter where you are in the country, it
15 all goes into this medical internet. And these
16 EMRs are plug and play. You plug them in, it
17 extracts the data into the format that they have.
18 And then when you're done it gets uploaded into
19 the internet. And you decide which doctor will
20 see your information or not when you start seeing
21 them as a patient.
22 And there may be some overriding thing

1 that the ER has certain access to certain fields
2 or something of that nature.

3 So that would be my thing. So, if
4 anyone ever has any interest in looking into
5 that, I know nothing about IT, except like the
6 pie in the sky type ideas. So you let me know.
7 But that would be my idea. Because I think it's
8 important to have it up there.

9 I don't believe any one person owns
10 the data, like if it should be regarding a
11 patient and that, you know, we should get away
12 from doctors owning the data and the EMR systems
13 owning the data. Who, is it with something
14 that's in the cloud, is it server-based or
15 whatever. It should just be there so we're able
16 to take care of our patients.

17 It would help with a lot of the
18 measures from primary care perspective, not
19 necessarily for ED transitions. But who's had
20 their mammogram? Who's had a colonoscopy? Who's
21 had this test within the past six months. It
22 would decrease duplication of data. And I think

1 it would take away a lot of those measures and
2 box clicking that a lot of the primary care
3 doctors have to do on a regular basis. That's
4 where my ideas come from.

5 Now getting back to more about the ED
6 transitions. The one thing I wanted to make sure
7 that we're all aware of is that it has to be
8 patient centered. I know that's a catch phrase
9 but it seems like when we're talking about all
10 these different ideas of what we should do when
11 it comes to transition of care, we're talking
12 about policies. I didn't get into this to be a
13 policy maker. I enjoy doing this stuff in my
14 free time. But I got into this to see my
15 patients and take care of my patients.

16 And when I'm in the room I don't care
17 about population health, I only care about the
18 patient in front of me. So anything we do has to
19 be related to that patient in front of me,
20 whether it be with this or any other measure that
21 NQF deals with.

22 It has to be realistic in the fact

1 that it doesn't interfere with the work flow in
2 taking care of the patient, that we become box
3 checkers that someone has talked about. And I
4 think one, in my academy someone has the phrase
5 "box-checking gofer." So I talked to Arjun
6 yesterday about how there's a recent study
7 showing that patient -- physician work has
8 transitioned. I think it's 53 percent EMR work,
9 47 percent patient-related work.

10 We've got to get back towards patient-
11 related work. So anything that we're doing for
12 these transitions and for these other measures,
13 we have to make sure it's not interfering with
14 that even more. Because, again, I got into this
15 to take care of patients, not to take care of the
16 measures necessarily.

17 And I know the measures are important
18 in helping to help see how we're doing. We need
19 to know what our problem is before we can address
20 it. So I understand the meaning behind it and
21 the need for it. We just have to make sure it
22 doesn't interfere with work flow.

1 The other --- there's two other points
2 I'll make. One is we talked about
3 accountability. And it's listed as the first
4 bullet point there under the first heading. I
5 was talking with my group earlier, so they heard
6 me say this before, I think collaborative care is
7 more important because accountability it seems in
8 my mind that someone's responsible if something
9 goes wrong. And I think if we're going to
10 progress, we can't be pointing fingers that look
11 more at the process, the system, and the team
12 approach to doing things.

13 The accountability thing, unless it's
14 a team-based meaning of what can we do better to
15 improve our outcomes, to me that looks more like
16 we're protecting our rear ends in case of
17 potential lawsuit or something else of that
18 nature. I don't -- again, it just doesn't sit
19 well with me.

20 And, lastly, as Jesse mentioned
21 earlier, reimbursement's an issue, especially for
22 primary care. We're the lowest paid specialty in

1 the medical field. And we seem to shoulder a lot
2 of the burden of the measures that come through
3 because everything applies to us. You know, when
4 it comes to primary care, when it comes to
5 transitions, when it comes to GYN care, when it
6 comes to preoperative care, everything sort of
7 sits back onto us.

8 We need to start getting better
9 reimbursement with these measures for non face-
10 to-face care and for coordination of care. A lot
11 of organizations are starting to do that with the
12 CPC+ and the APM's, with per member, per month
13 fees. Capitation is coming back but they're
14 called other things now. So I think that you
15 have to remember that the more burden you put on
16 outside -- well, we have to get paid for that
17 time.

18 You know, I was talking to someone at
19 dinner last night, and if you sell wrenches and
20 you sell a wrench for a dollar a wrench, but now
21 the new regulation comes in asking you to start
22 doing inventory which I didn't have to do before,

1 now I just have other regulations and measures,
2 well, I'm going to start charging more for the
3 wrenches because I've got to cover my staff time
4 to do that. No one's increasing my pay to do the
5 extra work that needs to be done for these
6 measures.

7 So I think that's -- it isn't just
8 primary care, but anyone who is required to do
9 these measures should have some type of bump in
10 their non-face-to-face patient care income.

11 So, thank you. Sorry for my rant.

12 CO-CHAIR NILES: No. Thank you. That
13 was very good.

14 Stephanie, you've been waiting
15 patiently.

16 MEMBER WITWER: Thanks. On a little
17 bit different note, I think we need to develop
18 systems that bring the payers, the patients, and
19 the providers together. We have a lot of
20 redundancies in our systems. I don't think our
21 patients understand the benefits that they are --
22 that they can receive through the payers. I

1 don't think the providers understand the benefits
2 that the payers have. I don't think the payers
3 connect to the providers in the provision of
4 care.

5 So we're spending more money providing
6 more fragmented services but we're not bringing
7 them together in any meaningful way. So, there
8 are regulations that I think we need to think
9 through or to change regarding sharing and
10 working together as a system that would include
11 the payers.

12 CO-CHAIR NILES: Thank you. Jim.

13 MEMBER DUNFORD: Thanks for having
14 another chance.

15 Just looking holistically, you know,
16 I, as a city medical director I sort of dream of,
17 you know, the whole thing working collaboratively
18 like a wonderful synergized system, and everybody
19 gets to go where they belong and all that type of
20 thing. And the whole notion of re-thinking what
21 is an emergency department, you know, I really
22 don't want to get stuck in the 20th Century model

1 and then try and fit all this stuff into it.

2 I think ACEP and a lot of others need
3 to kind of write a white paper that says, you
4 know, what's the emergency department really all
5 about and what can it do? What are the untapped
6 opportunities? And then design a system for it.

7 You know, the ED is the bad guy now.
8 But, in fact, that is really a very poor
9 characterization of what the emergency department
10 is. It's the one place to find out what's the
11 matter within five hours, of almost anything. We
12 can stage any condition 24/7/365. We're the only
13 place you can get an MRI, you know, at 3:00 in
14 the morning. We are it in terms of alleviating
15 anxiety and defining the problem.

16 And people tend to think of us as this
17 sort of wasteful, chronic place where money goes
18 down the drain. And I think that really needs to
19 be re-looked at.

20 Furthermore, I really think that the
21 staffing of emergency departments need to be
22 completely transformed. Really, in order to

1 accomplish in a global payment system, or
2 whatever we're moving away from fee-for-service
3 and toward that, the emergency department becomes
4 an integral part of figuring out what's the
5 matter and what you do next on Saturday afternoon
6 when other people can't see that patient.

7 And so, all of our efforts, you know,
8 we were all -- we've always known we're the front
9 door. But everybody treated us like the back
10 door. Really, the ED has been thrown under the
11 bus for three decades, you know, while oncology,
12 and cardiology, and every other resource was
13 expanded and built and got case managers and
14 everything else. The emergency department was
15 the loss leader of the hospital. And, you know,
16 that just has to go away. Because really what we
17 are is the gatekeeper. We are the financial
18 gatekeeper for these payers. And we have the
19 ability to do this cost-effectively, if we have
20 the right tools to do it.

21 So, I compare this to, you know, if
22 you have a Navy Command and Control Center or an

1 Air Force Command and Control Center, that's
2 really what the ER should be. It should have at
3 least one, why not three social workers and case
4 managers that are dealing with these patients to
5 get them home and lose all of that wasteful and
6 unnecessary admissions. There is countless --
7 and I'm sure the infomatics is very important and
8 will be able to do this -- but a lot of times
9 it's just time pressure. And so kind of a re-
10 understanding of what the resource of an
11 emergency department is to a community and how it
12 basically serves this essential role.

13 The other thing, and I'll just shut up
14 after I say, is there is a new thing called Next
15 Generation 911 that's coming. Right? The
16 ability to push and pull information through 911
17 systems from the home, to the home, to the
18 whatever, to have broadband video and the
19 capacity for emergency physicians or others to
20 actually care coordinate, not just acute diseases
21 but chronic diseases, is coming real quickly.

22 In Houston they've got two ER doctors

1 that basically on an iPad talk to paramedics all
2 day long about whether that patient needs to go
3 to the hospital or whether he can -- in an
4 emergency room, or if he can get an appointment
5 in a clinic. You know, David Persse, the medical
6 director of Houston, set that up three years ago.
7 And these models are growing all over the place,
8 coupled with community paramedicine.

9 This is all under the wing of
10 emergency medicine, EMS, and the capacity of us
11 who have -- we've always given radio acute, you
12 know, direct online medical control. But for
13 those times of acute and chronic conditions,
14 there's a giant repository of ideas and concepts
15 of what emergency medicine can do to lower costs
16 and approve healthcare and better match a patient
17 with resources.

18 So, I just think people really need to
19 keep that idea in mind. I mean it's very
20 tempting, and hospitals oftentimes pigeonhole
21 emergency departments, and they're the last ones
22 to get much in the way of new services.

1 But at least at my hospital we never
2 have, you know, they never build an ER too big,
3 it's always too small. But the concept of what
4 it should be doing down there and how it's going
5 to save money in the future, driven by payment
6 reform, I think is underestimated.

7 And so I'd like to see that, you know,
8 really get spelled out, as what is the vision of
9 the future of an emergency department?

10 CO-CHAIR NILES: Great.

11 Joe, you have something?

12 MEMBER KARAN: Yeah. I want to follow
13 up on something that Jim said.

14 He mentioned having social workers in
15 the ER. With what we're talking about today and
16 the ability to reach out to the community
17 resources, that is by definition a social
18 worker's job. And it takes the burden off of
19 nursing, physician. And the social worker will
20 reach out, make all those lists together that
21 everybody wanted of the resources that were
22 available. That's why they go to school. I

1 mean, they're trained to actually do that.

2 And I don't know where we would be in
3 our clinics if it wasn't for the social worker
4 finding out where the resources and
5 possibilities, homes, temporary housing, you
6 know, whatever, access to free medication.
7 That's something that they all work on.

8 So I love the idea of having the
9 social worker involved in the emergency room.

10 CO-CHAIR NILES: I would challenge you
11 that you won't necessarily have to have a social
12 worker. You can have a highly-trained community
13 health worker, M.A., somebody that's doing that
14 work. But, you're right, it's that team that
15 does that.

16 MEMBER KARAN: Yeah. A lot of times
17 it goes to the case manager.

18 CO-CHAIR NILES: Yes.

19 MEMBER KARAN: And I have found
20 through my experience over the last eight years
21 that a case manager and a social worker do have
22 some differences.

1 CO-CHAIR NILES: Absolutely.

2 MEMBER KARAN: What I see is case
3 workers, they're there to get the person out of
4 the hospital. Okay. What do we have to do?

5 MEMBER CARDEN: This is Donna -- I'm
6 sorry, this is Donna Carden. Can I say
7 something?

8 CO-CHAIR NILES: Of course.

9 MEMBER KARAN: Of course.

10 MEMBER CARDEN: Sorry. I didn't mean
11 to interrupt.

12 But, you know, building on what Joe is
13 saying and Jim said, Jesse Pines and I recently
14 were involved in a publication where we actually
15 measured patient activation -- patient engagement
16 using the patient activation measure in older,
17 chronically ill patients who were discharged from
18 the emergency department and then were visited by
19 a healthcare coach out of the ED. Most of these
20 programs -- this is based on the Coleman model --
21 and most of these programs have been done in
22 admitted patients but we did it in patients who

1 were discharged from the ED.

2 And what we found -- just building on
3 what you guys are talking about right now -- is
4 that the very ED visit per se engages patients as
5 measured by the patient activation measure. And
6 so there -- so it is measurable, it's just a
7 little squishy. And what we found is that the
8 very act that the patient goes to the ED for
9 their healthcare crisis actually engages them.
10 But that wanes pretty significantly over the
11 ensuing 30 days.

12 What was very interesting is that
13 while it still fell in patients who were coached
14 with a community health worker, actually the
15 coaching significantly blunted, significantly
16 decreased that fall in patient engagement. And I
17 think building on the discussion that we're
18 having right now, it may be aspirational, but if
19 some of these resources that are traditionally
20 assigned to inpatient wards would be reassigned
21 and realigned with the emergency department, we
22 could probably do a better job of engaging or

1 keeping patients engaged after that ED visit that
2 currently we're not doing.

3 CO-CHAIR NILES: Great. Thank you.

4 Aleesa, you've been waiting patiently.

5 MEMBER MOBLEY: My question goes back
6 to Jim. When you talked about a white paper for
7 the emergency room -- now this is coming from
8 someone who is not a physician, don't work in the
9 ER -- I have in the past, but not recently -- if
10 the emergency room was 75 to 85 percent primary
11 care and then we developed and we explored all
12 these wonderful trauma centers, then what is the
13 definition, what is left for the emergency
14 department that we're trying to capture and
15 maintain for those transitions of care? Because
16 all those other entities are still out there and
17 they're still growing.

18 MEMBER DUNFORD: I'd say they're
19 growing, but at the same time the volume into the
20 emergency department is just -- continues to rise
21 and rise and rise. And the number of people
22 using ambulances continues to rise and rise and

1 rise. And so whatever those resources that are
2 being created are unable to match the demand.

3 And so the emergency department is all
4 of the things that you're talking about. I mean
5 it is everything from medication refills,
6 unfortunately, to, you know, all these acute
7 unplanned visits. And I think we have to be
8 prepared for that.

9 But, you know what, in this world
10 these days people can't wait three days to get a
11 CAT scan, they're going to get it now, you know.
12 And undifferentiated pain requires a work-up
13 these days, it can't just be -- you can't just
14 send somebody home with narcotics and say, come
15 back. I think you might have ovarian cancer.
16 We'll work it out in ten days.

17 You know, I mean we work that up. And
18 we define what the problem is in a way that
19 couldn't -- when I was an intern in 1976, that
20 was the old school. Here's your pain medicines.
21 Let's give you a guess about what's going to
22 happen to you.

1 But I don't know, we just offer a
2 different kind of time-ready solution and staging
3 process for all kinds of issues, from fractures
4 to, you know, to the most complex migraine
5 headache that might be an aneurysm that nobody
6 wants to miss. So, I don't know.

7 Arjun, what do you think? I mean
8 where do you see yourself, and also has ACEP got
9 a view of where things are going with the ED of
10 the future?

11 MEMBER VENKATESH: So, I mean, I think
12 there's a couple of things here. One is I
13 totally agree with Jim on a lot of this. I think
14 what it means is that we're redefining the work
15 of the emergency department and we're redefining
16 the work of the outpatient inventory care world.

17 I think the mistake is to set this up
18 as in a world to say -- just like it's a mistake
19 I think to create measures that will just support
20 the fee-for-service architecture, it's also kind
21 of a mistake to set up a conceptual framework
22 where we say, okay, the way to optimize care

1 coordination is to get all patients back into an
2 acute, unscheduled care episode that fits the
3 system we want defined for them that's convenient
4 for providers and convenient for payers and
5 convenient for the system.

6 It would be really convenient if when
7 you had undifferentiated abdominal pain and
8 abdominal swelling for everybody but the patient
9 if we said, oh, you call your primary care
10 provider first. They will answer the phone and
11 they'll schedule an appointment when it's first
12 available. You will go see them. They'll
13 schedule you for a CAT scan in two weeks. We
14 will get that done and then we'll get back to the
15 results.

16 But that's not -- that's only
17 convenient for everybody but the patient. And so
18 if we do it in a patient-centered way, acute,
19 unscheduled care and illness requires instant --
20 right -- diagnostics, instant treatment and
21 instant care transition. And so that's why even,
22 like, setting up our care transitions out of the

1 ED to be like, oh, we'll try to get this done in
2 a couple weeks doesn't make sense, because that
3 doesn't fit the patient's acute, unscheduled care
4 needs.

5 And so I agree with you, I think that
6 this redefines how you deliver things, what kind
7 of resources you have and where you put them.
8 I'm not sure it makes sense to have, like I've
9 said, five care managers around. You could take
10 the same dollars from five places, put them at
11 care managers where they touch the patient, and
12 maybe that's only in the emergency department.
13 Right? We don't need a fund to have care
14 managers all over the world. Maybe there is an
15 acute care transition hub where you put all your
16 resources locally.

17 You can have a kiosk for care
18 transition like you have an observation unit for
19 care transition. We could redefine care
20 transition not to try to be how do I fit it into
21 my old system which is you go from this provider
22 to the next provider to the next provider, and

1 instead say I'll make it totally patient-centered
2 and we'll come to the patients -- right -- where
3 they are for care transition.

4 So that's one sort of view on this.
5 Where is ACEP on this? I think, you know, most -
6 - medical specialties aside, I would say all this
7 stuff is still built on how do we work with their
8 existing regulatory system and an existing
9 payment system. And almost virtually all
10 emergency medicine payments are fee-for-service.
11 And the reason this matters, I think, is people
12 think that they see all these hospitals and
13 health systems joining ACOs and bundled payment
14 packages and all these new payment models, that's
15 not true for emergency medicine.

16 And I think it's important to
17 recognize that the emergency physicians,
18 emergency clinicians are not hospital employees.
19 Virtually none are in this country. And so you
20 can have all the ACO penetration you want across
21 the country, and every hospital and health system
22 join a shared risk arrangement with their private

1 payers, it does not change how we're paying for
2 emergency medicine. Emergency medicine is still
3 paid fee-for-service underneath that everywhere.

4 And so the give and take here comes in
5 a world where, okay, if you change the payment
6 system for hospitals and you've got these
7 hospital-based providers there, maybe the payment
8 system allows reinvestment of resources -- like
9 people have been talking about -- for care
10 coordination, social work in the emergency
11 department setting or this acute transition
12 center. And that's the way that this works.

13 Because right now we're not paying any
14 clinicians. And we're not near paying clinicians
15 non-fee-for-service. I don't think we even know
16 how to do that. ACEP's trying to convene an
17 Advanced Payment Model Task Force. That is years
18 away from having an APM that could work for
19 emergency medicine.

20 So those who are in the primary care
21 world and know the CPCI work that's done as an
22 alternative payment model for primary care, that

1 took years in the making. It's been a decade to
2 build some sort of model that works and a little
3 bit of payment to it. We are equivalently that
4 far away for emergency medicine.

5 And so I am with you. I think the
6 work has to get redesigned. I'm not sure that
7 the specialty side is going to get us there
8 overnight.

9 The other thing that is related to
10 this -- and I think it's worth bringing up -- if
11 there's a default in these rooms -- and I
12 mentioned this yesterday because we are all from
13 the healthcare sector -- to say, oh, they need
14 more community resources, or we're not using
15 community resources, I don't know. Everybody
16 that I have seen that needs Meals on Wheels is
17 getting Meals on Wheels.

18 We do not have patients unconnected to
19 Meals on Wheels in our emergency department.
20 Maybe it's because we're a small community.
21 Maybe it's because our Area Agency on Aging is
22 pretty good. Our coordination failures are not

1 that there are services available that that
2 patient cannot access. There may be services
3 available that have run out of money -- like Joe
4 mentioned -- too early in the year and so,
5 therefore, they're not available because they're
6 under-resourced or we haven't made social
7 investments in them.

8 I can promise you everybody who is at
9 high risk of a poor ED care transition failure
10 has already heard about services. They've had
11 enough social work visits in the previous amount
12 of time period. It's just that we haven't
13 integrated those services and that help in a way
14 that is useful in patient centers. We've tried
15 to use them but kind of pushed them back into our
16 system.

17 And so I bring that up because I think
18 sometimes there's an easy out in these meetings
19 to say, oh, well they just need community
20 resources or they need community services, and
21 kind of push it outside and say that's not our
22 job, that's not our work. And I'm not

1 necessarily sure that that is -- and it's
2 provocative to say, I know, and I recognize that
3 -- I'm not sure that's necessarily like that
4 there's some magic fix in community resources
5 that will just make this problem go away. It's
6 not going to happen.

7 CO-CHAIR NILES: Thank you. Karin.

8 MEMBER RHODES: So, in terms of policy
9 recommendations that might address a little bit
10 of both of these things, I think we could use
11 some -- in terms of redefining the role of the
12 emergency department -- and maybe it's allowing
13 us to use fee-for-service payments, when we
14 identify patients at high risk of a poor care
15 transition, that we could basically put them in
16 some sort of obs and do intensive care
17 coordination right there.

18 And, clearly, if it's in the ED, it
19 needs to be 24/7. That's the one thing, whether
20 it's social work, care coordinating, health
21 coaches, linking people into disease management,
22 finding them a primary care provider.

1 And so the key would be identifying
2 this high-risk group -- which I think we're in
3 the middle of trying to work on, you know -- more
4 than two ED visits in a month, polypharmacy,
5 sentinel events like falls in the elderly, we can
6 identify those sort of things, or a new serious
7 illness, a tumor identified on chest X-ray, da-
8 da-da. And rather than send those people out,
9 why not do the care coordination, do the rapid
10 work-up, and get them linked in right there.

11 But we would need a slight payment
12 alteration around that. And I don't know if you
13 want to talk about the model you mentioned, but
14 people are using this sort of model. And it
15 would, you know, possibly help solve some of the
16 problems even in the current system.

17 CO-CHAIR NILES: So you're really
18 talking -- let me make sure I'm understanding --
19 you're really talking about two things, policy
20 change and payment reform.

21 DR. PINES: We talked about this
22 earlier. So, so that there are some sort of

1 emerging models that are -- this is more in the
2 private health insurance space where the
3 emergency department is contracting or ED groups
4 are contracting with insurers around care
5 coordination activities, where there actually is
6 higher payment.

7 The example -- I can't think of the
8 name, but one of the big physician -- ED
9 physician groups is partnering with an insurer
10 down in the South to -- if they can increase
11 their primary care follow-up for COPD patients,
12 that they will pay higher ED fees.

13 However, the message back from the
14 insurers is the emergency physician group has to
15 go at risk for that, which they were happy to do.
16 And they actually put in several programs that
17 are not -- this is not at the sort of individual
18 ED level but this is at the ED physician group
19 level, to address some of these care coordination
20 issues for high-risk patients.

21 CO-CHAIR NILES: Thank you.

22 Let me get to Brenda. Brenda has been

1 waiting. So we'll go to Brenda and then back to
2 Arjun.

3 MEMBER SCHMITTHENNER: Well, I was
4 born in Connecticut. And it sounds like when I
5 retire I need to move back to Connecticut because
6 I assure you that there are indeed wait lists.
7 There are long wait lists for many social
8 supports for people of all ages and incomes.
9 There is a shortage of community-based providers
10 because of scarce revenue.

11 When there are budget cuts on the
12 federal or the state side, those cuts are to
13 social services. And we have completely built a
14 system in which there is an increased demand for
15 those social supports, but a lack of resource
16 increase to then provide those services.

17 It has been an unintended consequence
18 of identifying social determinants and
19 understanding that if people's needs are not met,
20 that does become a burden on the healthcare
21 delivery system. So it's a win/win that we
22 finally get recognition that, gee, the supports

1 that are in the community really are important.

2 But definitely there has to be policy
3 change in which if the demand is going to
4 increase and the burden is going to be shifted to
5 the community, then so does the sources -- you
6 know, resources in order to support those
7 services. And that's going to involve policy
8 changes. And right now those policy changes are
9 not moving in that direction.

10 When you talk about the primary payer
11 for social supports for low income, is Medicaid.
12 Per capita caps is going to cut those services
13 significantly.

14 When you talk about older services,
15 older age services, those are through the Older
16 Americans Act. Those -- there has been no
17 increase in revenue. So nutrition, chronic
18 disease self-management, in-home care, most of
19 those services that you rely on for people over
20 65 have not received any increases, and yet the
21 population is the fastest growing population in
22 the country.

1 CO-CHAIR NILES: Thank you.

2 MEMBER VENKATESH: So, Brenda, I
3 totally agree. And I think that this gets to
4 what Jim was saying around the idea of where do
5 we spend the money? We spend it on inpatient
6 hospital care, right?

7 So, I think the catch to what I was
8 trying to say is that it's not that the referrals
9 are not happening. The referrals are happening
10 to an empty or lack of community services or
11 supports. And so we'd have to figure out a way
12 at the policy level to take dollars and not spend
13 those same dollars on inpatient hospital care,
14 but instead spend them on community social
15 supports. And that is a very challenging,
16 difficult financial transfer to pull off in our
17 current existing system. I agree with that.

18 I think the other thing I was thinking
19 as people were mentioning this, we all agree that
20 if you have a heart attack that you need to be in
21 the emergency department and you need to get
22 hospital-based -- you need acute unscheduled care

1 that day. We actually almost also have agreed on
2 the fact that if you have symptoms suggestive of
3 a heart attack, chest pain, that you need acute
4 unscheduled care that day.

5 And so we have this idea of time-
6 sensitive illnesses and acute injuries and
7 illness that need emergency care.

8 Care coordination historically we
9 frame under a concept as being a chronic problem,
10 a chronic management issue. What if instead your
11 lack of care coordination is your acute illness
12 or injury? And so that's true for a lot of
13 patients. We see many of these patients when
14 their primary problem that day -- right -- is
15 acute illness or injury. So that's why we've
16 done things like try to get social workers and
17 care coordinators into the emergency department
18 and make them patient-centered. Because just
19 like you can't wait two weeks to get that CAT
20 scan, you can't wait two weeks to get your care
21 coordinated.

22 And so, the other thing that we could

1 move this towards a model of is trying to think
2 about a world in which you say, okay, acute care
3 coordination is in and of itself a service, a
4 need, a gap. And that's why it has to be, like
5 Karin said, delivered 24/7. That's why it has to
6 have a variety of things built around it. And
7 that's not something we have in our system right
8 now. We don't do -- we don't have an acute care
9 coordination.

10 But that may be what's unique about
11 the emergency department in this case.

12 CO-CHAIR NILES: Thank you. Julie.

13 MEMBER MASSEY: We said it in a couple
14 different ways but I just would like to
15 reiterate. The key that you started to mention
16 is our incentives are not aligned around those
17 kinds of initiatives. Our incentives are aligned
18 around payment for acute care. All of the
19 reasons you mentioned for the carve-outs when you
20 look at primary care and the resources -- when
21 we've put measurement in place we've created
22 codes. We then put in a structure to balance

1 that -- those resources. We then start
2 recognizing how much they cost. And we start
3 working to shift those resources to less of an
4 acute care mindset.

5 And I like the idea of thinking of
6 lack of care coordination as actually one of
7 those things that can cause an acute episode.
8 But we need to be able to capture that and
9 measure that, which is why we're here, to try to
10 -- we need to align our physicians, our
11 specialists, our primary care, and as well as our
12 ED into the same directions so we're
13 incentivizing them for the care we want, not just
14 reactionary care.

15 CO-CHAIR NILES: Great. Thank you.

16 Jim.

17 MEMBER DUNFORD: Just one last thing
18 is what I've observed a lot of times is that the
19 most expensive patients -- the management of
20 these patients has been cost shifted to who? To
21 the police department and the fire department.

22 So if you really look to see where the

1 majority of the care coordination and patient
2 care that happens for the most expensive people
3 in your city, it's really they are being managed
4 by the police department and being put in jail
5 and taken out of jail. And so it's really a form
6 of cost shifting to the taxpayer in a different
7 kind of way.

8 And this is actually really starting
9 to blow up. I mean, fire departments around the
10 United States -- fire chiefs are apoplectic about
11 this, about this issue. Police chiefs are
12 apoplectic about this issue, about the fact that
13 they are managing chronic mental illness and
14 bringing them repeatedly to emergency departments
15 for medical clearance again and again, and
16 filling up their jails.

17 So, really, just in the idea of if we
18 really want to tackle this the right way, who are
19 the stakeholders again? The stakeholders are the
20 people that are actually just as bummed out about
21 how bad it is as we are. And there are very few
22 affiliations that you find really meaningful

1 associations where you really bring those kind of
2 community stakeholders to the table and actually
3 come up with solutions.

4 We have a terrific program for chronic
5 homeless alcoholism in San Diego that's been
6 operating for 17 years, where it's a partnership
7 between the superior courts and the police
8 department, the fire department, the emergency
9 departments, the public defender, you know,
10 everybody. And it really moves people into a
11 choice between, frankly, incarceration or
12 treatment. And it actually works.

13 So, those kinds of solutions, you
14 know, to chronic homelessness, there was no other
15 solution until you really engage those kind of
16 people. And I think that that's the hard part
17 for emergency departments, who are the front door
18 to all these issues, we are the -- we're dealing
19 with those people -- is to kind of get a
20 knowledge and expertise in the emergency
21 department of what's going on out there. Really
22 the bottom line, with all due respect, most

1 hospital social workers don't know what's going
2 on downtown. They know the names of the
3 facilities but they don't know the people. And
4 the connections really have to be built.

5 So, that's my pitch, is to create more
6 of kind of a -- you know, interdisciplinary teams
7 is where EDs are actually collaborative. And
8 this concept of when you -- since hospitals,
9 according to the Accountable Care Act, have to do
10 these community assessments and periodic needs
11 analyses, that those are the kinds of things that
12 they prioritize for their programs. And that
13 they really -- if they're going to maintain their
14 nonprofit status, that this is the way they do
15 it, through these kind of collaboratives, rather
16 than just saying, well, you know, I have
17 pediatric asthma in the community and we need to
18 get the mold out. Everybody knows that.

19 CO-CHAIR NILES: All right. So we've
20 heard a lot of barriers. Do we have -- we had
21 some specific policy recommendations. What about
22 the role of technology? I know we've touched on

1 that a couple of times. What is the role of
2 technology? And if there is a role, what is it?
3 Julie.

4 MEMBER MASSEY: I think it's an
5 enabler. It's some of the found -- when you have
6 some of the foundational elements with the push
7 towards incentivizing for meaningful use. We've
8 got some of our information where it needs to be
9 to be able to move to that next level. But we
10 have a lot of work we still need to do to
11 optimize that.

12 We've got to move very quickly. It's
13 a foundational enabler. I don't think it can be
14 this total solution to the issue but it's
15 something that has to enable the rest of what
16 we're talking about.

17 CO-CHAIR NILES: Joe.

18 MEMBER KARAN: It's also the gateway
19 to the patient's next step when they receive --
20 they leave the emergency room. It's -- on IT
21 you're looking at all the programs that are
22 available that can be found. Are they difficult

1 to find? Sometimes. Because IT's not perfect.
2 But everything that the emergency room would need
3 -- I'm not saying for nurses or physicians -- I'm
4 just saying everything the emergency room would
5 need to take that patient and release that
6 patient into the community exists. It's not new,
7 it's already there.

8 The problem is finding it, dissecting
9 it to see what works and what doesn't work.
10 That's not there. Everything's there en masse.

11 But -- and also if I can -- when the
12 patient's leaving the emergency room and the
13 comment you get is -- you ask them about the cost
14 of drugs, can they afford it? And let's say the
15 answer is no. What happens at that point in the
16 emergency room? Does something else happen, for
17 example, that they know that numerous
18 pharmaceutical companies have low-income programs
19 for virtually every medication that's out there.

20 Is that information given to the
21 patient or not? I mean, I don't know. It would
22 help the patient I think -- to gather it, yes.

1 That's why I think that pre-gathering information
2 is the best way to do it, if we can. But, you
3 know, in the emergency room there's such a
4 breadth of situations.

5 CO-CHAIR NILES: And to back it up a
6 little bit, to build a little bit on what you're
7 saying, when you ask -- I tend to caution people
8 never to ask a person if they can afford their
9 medication because, number one, they don't know
10 what it's going to cost. And a lot of people
11 will always say, yes, of course I can afford
12 that.

13 A better question might be, you know,
14 if this medication costs \$1,000, what are you
15 going to do about that? So that's one thing to
16 kind of back it upstream because -- and many
17 times the physician or the social worker or the
18 nurses in the ED -- if there's not a clinical
19 pharmacist there, they have no idea what it's
20 going to cost. And they have not accessed the
21 payer's formulary to know if it's even on the
22 formulary or whether it will be covered or what

1 it's going to cost.

2 So there are a lot of little nuances
3 there that I think we've really got to address to
4 make that come true for what you were saying. I
5 agree.

6 Aleesa.

7 MEMBER MOBLEY: Yes, as far as
8 technology, wonderful tool. Unfortunately, the
9 barriers are it costs a lot of money, and it
10 costs a lot of money for the upkeep. It has
11 great promise. But many of us assume it can do
12 things magically. It can't do everything without
13 the correct input, such as syntax, language.
14 Lots of data goes in, but there has to be some
15 commonality to pull that data out to make it
16 useful.

17 And while I was going through all
18 this, the little lightbulb went off for some
19 aspiration. For those high-risk, high-acuity
20 patients who are in and out of your emergency
21 room all the time, we have soldiers who wear dog
22 tags all the time. We have elderly patients with

1 medical alert bracelets on for their allergies.
2 Can we get those patients some kind of grant so
3 that we can get them a little flash drive
4 bracelet so that all of their health records are
5 right there?

6 CO-CHAIR NILES: Great use of
7 technology, yes?

8 MS. COBB: I would actually just say
9 we did a key informant interview with a SNF, and
10 they were actually doing that. When they
11 transported folks to the ED they would, you know,
12 tape a thumb drive or have a certain information
13 packet that went specifically with them. Analog,
14 you know, yeah.

15 CO-CHAIR NILES: Okay. Amanda.

16 MEMBER PEARSON: I think -- going to
17 the point on the prescriptions, I know some EMRs
18 have that capability. So when I prescribe
19 medications -- and it's not all the time, so I
20 don't know why it works for some patients and not
21 others -- but I'll get a list of this is level --
22 this is Tier 1, Tier 2, Tier 3, Tier 4, not

1 covered on your formulary. And it will sometimes
2 even give me the cost. Other patients it's not
3 there.

4 But I think that those -- there are
5 capabilities that are available that can be built
6 in. And I think it is helpful because a lot of
7 times you're choosing among multiple medications,
8 and it doesn't matter if I prescribe medication A
9 or medication B to me, but to the patient that's
10 going to matter quite a bit. And so I think that
11 those are things that we could build in as
12 potential quality aspects and encourage our EMR
13 friends to flesh out a little bit more.

14 I think one of the other big benefits
15 of the EMRs are the capabilities to have little
16 preset reminders and pings. And I know that
17 there is always the risk of too many pings and
18 alarm fatigue, and you just ignore them. But
19 then there is also the -- you know, there is also
20 -- when a high user or a high-risk patient comes
21 into the ER, maybe there's a little red box at
22 the top of the screen that flags this as a high-

1 risk patient.

2 Or maybe there are things in the EMR
3 where when you discharge a high-risk patient, if
4 that patient hasn't seen their primary care or if
5 a prescription hasn't been filled, maybe a
6 notification goes out to their primary care
7 provider, or a notification goes out to the
8 patient like this -- our record is showing that
9 this prescription was not filled. You did not
10 pick this up. Like, reminder to do this. Or,
11 we're showing that you did not see your
12 physician. Reminder to contact your physician.

13 I mean there's -- I think there's a
14 lot of different ways that EMR can be helpful to
15 us that we really haven't developed.

16 CO-CHAIR NILES: Jim.

17 MEMBER DUNFORD: We were very lucky in
18 San Diego because we were one of the Beacon
19 communities. So we got whatever that was -- \$15
20 or \$16 million -- that came to kind of build an
21 HIE. And, fortunately, the PI on the grant was
22 the Chairman of Emergency Medicine at UCSD, a guy

1 named Ted Chan.

2 So I got to have a certain amount of
3 input into the thing, including the idea that EMS
4 bidirectional exchange would be a valuable thing.
5 So we've been building toward that for years.

6 And now we just got an ONC grant that
7 is now going to show the ability to send alerts,
8 file and reconcile records. So it's called SAFR
9 technology, which actually allows you to actually
10 impart the record permanently, tell the -- you
11 know, live feed information from the field. And
12 then ultimately, as we were talking about, get
13 information back.

14 So the technology is there. I mean
15 it's so critical that we all kind of expand the
16 idea of, you know, bidirectional HIE access.

17 Everybody probably knows the Academy
18 of Medicine recently identified I think it's nine
19 social determinants that should be incorporated
20 into the electronic health record. So that's
21 coming. Some of those are very static and some
22 of them are dynamic. So we're really talking

1 about the emergency department's ability to kind
2 of update social determinants, you know, like
3 availability of transportation and more variable
4 things. I think that's really going to be
5 valuable.

6 We recently had demonstrated a program
7 that has swept across Washington, Oregon, and
8 upper California called EDIE. And I think if you
9 just look at an example, I think it's the only
10 software that ACEP has officially endorsed. But
11 it carries the care coordination plan for a
12 patient -- complex patient. It began basically
13 as a way to kind of address pain-seeking
14 patients, and it expanded to something much
15 broader than that. But it has the ability to
16 share the care plan to every emergency department
17 and, really, probably across the entire HIE.

18 So HIEs can build these or they can
19 use this and take at least a look at what that
20 does because it is a tremendous asset to being
21 able to find out, you know, what the management
22 plan is of the primary care physician.

1 And the other thing is alerting, too,
2 as Andrea was talking about, I just feel like we
3 have really underused the concept of alerting
4 technologies. You can use them in the field to
5 alert. We, three or four years ago, were
6 alerting case managers on patients that were, you
7 know, high-risk patients to let them know they
8 were en route to the ER, so the EMS providers
9 were letting them know to come and see that
10 patient in the field.

11 And this concept of the ADT alert, you
12 know, when a patient comes into the emergency
13 room and the patient's officially admitted to the
14 ED, that thing has all kinds of -- and there are
15 millions of transfers being executed all the time
16 in HIEs that the EDs probably haven't really
17 adequately harnessed.

18 So I just think that, you know, that
19 the technology that's inherent in this whole
20 thing is going to drive all this. I'd just get
21 back to, like, what everybody was saying, there's
22 privacy issues and lack of a uniform medical

1 record number to be able to really sync it all
2 together. Otherwise it's just probabilistic
3 matching and it can be complicated.

4 CO-CHAIR CANTRILL: Right. And I
5 think technology has to be used intelligently,
6 not just used. And that's a problem, certainly
7 as you're talking about alert fatigue in terms of
8 the guys sitting in from of the CRT for 90
9 percent of the time. That is pretty mind-
10 deadening and it leads to complete ignorance and
11 ignoring of the alerts.

12 Arjun.

13 MEMBER VENKATESH: I guess it's sort
14 of technology-related but, so systems like the
15 EDIE information exchange, this idea of having a
16 care plan they could follow, or at least the
17 ability to have some key information about
18 emergency visits, hospitalizations, care
19 providers that transfer people. It has been
20 implemented in several geographies.

21 I would say the challenge of all of
22 those -- and this from a management policy

1 perspective -- is that there's no business case
2 for something like that which has a huge clinical
3 case. And so you would ask, any clinician will
4 tell you, and even patients will tell you, yes, I
5 think it would be so valuable if you had that
6 information about my care. And every clinician
7 says, I absolutely need that information. But in
8 our current world, the investment in new
9 technology or a new IT is a largely hospital-
10 based investment. And there's actually no
11 hospital business case to invest in these EDIEs.

12 There may be in some very peripheral,
13 indirect way in a huge future when hospitals
14 change how they get paid. And if they're taking
15 population-based payments it might have value.
16 So in a state like Maryland where they've got a
17 global budget, there might be some business case
18 for them to invest in it. But even that, when
19 there's so many other things to invest in, it
20 never gets done.

21 So, I think there's this important
22 point to be made that there are certain amounts

1 of information exchange and information
2 availability in HIE that you almost need to
3 create a regulatory support for, or say that it
4 is in the public good and it is necessary in
5 order for us to actually provide care
6 coordination and not wait for the business case
7 to exist. For small segments of healthcare to be
8 able, it's never going to happen. They're not
9 going to invest in it.

10 CO-CHAIR CANTRILL: One more point. A
11 lot of this information needs to be pushed, not
12 pulled.

13 The PDMP is a good example of how if
14 you have information that has to be pulled, it
15 usually will fail.

16 CO-CHAIR NILES: Julie.

17 MEMBER MASSEY: So it's very
18 interesting. In the Philadelphia area and their
19 HIE approached this a little differently.
20 Because they struggled with the same thing: there
21 was not business care for the hospital side.
22 What they turned to was to say who in our

1 community is benefitting?

2 And they actually split the cost, and
3 I think it was 60/40, to the payers. Because at
4 that point the payers had the information and
5 could be the conduit to notif -- to identify who
6 needed to be notified because they were the only
7 ones. They know who they're paying bills for.
8 And they were -- so there's a combined, shared in
9 that cost between the payers and the large
10 hospital systems who had a choice to buy in. And
11 then individual providers could contribute at a
12 different kind of a rate.

13 So, it was an interesting approach.
14 Took a long time to do. But they did pick their
15 three main payers to be the receivers of that ADT
16 fee, and the notifiers that if their directory
17 became the notification to say who's the main
18 provider responsible who's been getting billing
19 for the care for this patient?

20 CO-CHAIR NILES: Amanda.

21 MEMBER PEARSON: You sort of echoed
22 what I was thinking that, you know, there is not

1 a business case now but how do you try and make
2 the business case? And the payers seem like the
3 most logical way to do that, unless the payers
4 and then the hospitals are going to change their
5 systems to follow the money. And maybe that's
6 the way to get around this, rather than just top-
7 down trying to force the hospitals to do
8 something to make it in their interest and with
9 the benefit of improving things for patients.

10 CO-CHAIR NILES: Great. Thank you.

11 Other comments? Marcia, do you -- are
12 we getting where you wanted to go? Yeah, I think
13 that we are winding down here a little bit.

14 Do we have any other comments? Oh,
15 Arjun.

16 MEMBER VENKATESH: If we're on the
17 topic of IT, there is one, it is like a, maybe
18 it's a personal gripe, but there is one actually
19 very near-term, feasible obstacle to effecting
20 care coordination and quality measurement in the
21 emergency department, and that is that the vast
22 majority of emergency departments use a different

1 EHR product for the ED than what the hospital
2 uses.

3 And so one of the primary challenges,
4 I'll tell you, in deploying the electronic health
5 record registry, the ACEP CEDR, the clinical
6 emergency data registry for quality measurement,
7 is that the only way to be able to do quality
8 measurement of hospital-based care is you have to
9 have permission from the hospital to the data
10 stream from the hospital, and permission to the
11 data stream from the clinicians.

12 And we have currently a system in
13 which the current policy incentives and business
14 case incentives will create a world in which you
15 can get the data stream from the clinician, but
16 the hospital's not particularly interested in
17 signing off that data stream.

18 And so there is a small
19 interoperability data exchange need there between
20 -- and recognizing that when you have non-
21 hospital-employed clinicians and hospitals
22 separate that you've got to, you have to -- both

1 of them have to share. Hospital-based clinicians
2 have to be able to get at this hospital data.

3 CO-CHAIR NILES: Operator, could you
4 open the line to see if we've got some comments.

5 OPERATOR: Yes, ma'am.

6 If you'd like to make a comment,
7 please press star then the number one.

8 And there are no public comments at
9 this time.

10 CO-CHAIR NILES: Thank you. Joe.

11 MEMBER KARAN: I'm going to apologize
12 for this statement ahead of time.

13 It's the patient's view. Okay? And
14 me being the patient, I'm going to tell you how I
15 just felt about the conversation about
16 technology.

17 In a world where everybody else is
18 investing in technology, if the place where I'm
19 going to depend my life doesn't, that's scary to
20 me. As a patient that is really scary. And the
21 fact that a hospital can't justify the cost?
22 Because I deal with that all day long with

1 patients that are dying because they can't get
2 the money to stay alive. And the emergency room
3 is where a lot of my people go, as in hospital
4 visits. Transplant patients and dialysis
5 patients have tons of visits to the hospital and
6 the ER.

7 And I actually would not re-say that
8 statement to anybody I work with myself, because
9 the competence that they need for the medical
10 care, if there are a number of patients, you
11 know, has the education to follow that I think
12 would be very scared by that comment.

13 And you also kind of made it sound
14 like it was kind of set in stone, that maybe
15 someday it will change. Well, my medical
16 problems aren't someday, they're now. And I find
17 the lack of technology or the softening of it or
18 the pulling back from it as something that could
19 really be dangerous.

20 CO-CHAIR CANTRILL: Just to put you a
21 little bit at ease.

22 MEMBER KARAN: Please.

1 CO-CHAIR CANTRILL: There is a lot of
2 technology that's been purchased in hospitals
3 across the country. In fact, it's been
4 accelerated, some would say inappropriately, by
5 the meaningful use. Certain things were pushed
6 out before they were ready. But I would say most
7 hospitals are very, very far ahead of where air
8 traffic control is in this country in terms of
9 the currency of the technology.

10 MEMBER KARAN: And you thought this,
11 with me flying out tonight, this was a good time
12 to bring that up?

13 (Laughter.)

14 CO-CHAIR CANTRILL: Just trying to
15 give you some context.

16 MEMBER KARAN: I'm going to be yelling
17 your name if I go down, I'm telling you.

18 CO-CHAIR NILES: All right. Do we
19 have any other comments about this?

20 (No response.)

21 CO-CHAIR NILES: Hearing none, let's
22 go ahead. And I'm going to turn it over to Kyle

1 and we're going to move on to what are our next
2 steps.

3 MS. COBB: Sure. Happy to.

4 Because I don't think anybody's going
5 to hear this. Everybody's eyes are on the door.

6 So we -- here is a little path of
7 where we are. And we've got through all the
8 purple squares. And this is how I'm going to
9 talk at this point. I think people are pretty
10 tired. We have a few more things to do. And
11 it's important, actually, to look at the sort of
12 the upcoming dates.

13 We will be finalizing our draft report
14 in less than a month, essentially a month. I
15 think today's the 26th of April, so a month from
16 today. But that means that we will be, in the
17 meantime, taking all the information that we've
18 learned so far, and even more so in the last two
19 days, assembling it in a report for which we'll
20 include the panel's recommendations and
21 prioritization of measures, measure concepts, as
22 well as this past conversation and all the sort

1 of anecdotal information we've picked up over the
2 last few days.

3 To that end we will be, we've surveyed
4 everybody in terms of available time for the next
5 few weeks for our small group get-togethers where
6 we will follow up with some additional directions
7 in how to score measures and rank them. I'm not
8 going to introduce any of that today. We had
9 thought we might. But what I will tell you is
10 that in the next few days everybody will receive
11 from their breakout group leader a summary of the
12 work that you've done, with instructions of what
13 to think about next.

14 And then we will meet in our small
15 groups on these TBD dates in the next few weeks
16 and we will discuss the next step in terms of how
17 we prioritize measures for the recommendations in
18 the report.

19 And then we will have our final
20 webinar on the -- or the next-to-last webinar on
21 the 4th to do our prioritization exercise, all
22 together.

1 So that was a lot of saying more to
2 come. Go home. Thank you.

3 Marcia has one more thing to say.

4 DR. WILSON: One more pitch on this
5 public comment in the report. We put out a draft
6 -- this is NQF process -- we put out a draft
7 report for public comment. It's out for a month.
8 The date there is actually incorrect, it's one
9 month.

10 If you have listservs and want to
11 share this report, we would love to have you do
12 that. Because the more people that can see it in
13 terms of public comment, the better. We'd love
14 to get the different, especially the different
15 stakeholder perspectives.

16 So what happens when those public
17 comments come back, staff will get all of them.
18 They respond to all of them. Now, sometimes the
19 response is "Thank you for your comment." Often.
20 But if there are, sometimes comments lead to
21 changes in the report. We get some great
22 feedback.

1 Also, that final webinar on July the
2 12th, the post-comment call, literally that's
3 when staff present what we learned in the
4 comments, what we responded. We may have some
5 themes that have bubbled up to share with you.
6 We may have some specific comments where you --
7 where we've crafted a draft response and say,
8 Expert panel, is this how you would like to
9 respond to this comment?

10 So, I would encourage you to just keep
11 those dates in mind. And when we push out this
12 draft report, please feel free to share them
13 broadly.

14 CO-CHAIR NILES: Jessica, do you have
15 any comments that you'd like to end with?

16 MS. OLDTMAN: Sure.

17 CO-CHAIR CANTRILL: Since you're
18 paying the freight.

19 MS. OLDTMAN: Well, I certainly am
20 not.

21 But on behalf of everyone at ASPR and,
22 you know, in particular Brendan and Gregg and I,

1 I want to thank everyone for coming. This was a
2 really, really great panel. It's really exciting
3 to see so many people at the table, really
4 interested, really engaged.

5 I think all of you can attest for the
6 fact this is really important work. And I'm
7 really excited. And I know Brendan and Gregg are
8 really excited that we are really pushing the
9 needle forward. And we appreciate everything you
10 have done and everything you will continue to do.
11 And we look forward to the draft report. So
12 thank you.

13 CO-CHAIR CANTRILL: Jim.

14 CO-CHAIR NILES: Jim.

15 MEMBER DUNFORD: Yes. I would like to
16 thank NQF. I think this has been a really
17 productive trip east from my point of view. I
18 really enjoyed it. You guys are all --
19 everything is 100 percent. There's only one
20 thing that I noticed, and it's on the last slide.
21 This arrowhead should be up one.

22 DR. WILSON: We need quality metrics

1 for that.

2 CO-CHAIR NILES: I guess we'll have to
3 start all over again.

4 Thank you all very much. We
5 appreciate it. We'll be in touch soon. Thank
6 you.

7 (Whereupon, at 1:25 p.m., the panel
8 was adjourned.)

9

10

11

12

13

14

15

16

17

18

19

20

21

22

A		
A,B,C 46:13,17	accurate 92:14 93:13	addressed 34:1,2 35:7
a.m 1:8 5:2 102:17,18	accurately 93:5 112:6	97:1
134:11	112:11	addresses 33:20
abdominal 165:7,8	ACEP 154:2 164:8	addressing 52:11
ability 75:18,20 89:3	167:5 191:10 198:5	adequately 192:17
111:20 122:18 139:22	ACEP's 168:16	adjourn 4:19 134:6
140:15 155:19 156:16	achieve 82:21 101:8	adjourned 207:8
158:16 190:7 191:1	achievement 4:9 77:17	Adjunct 1:21
191:15 193:17	79:7 125:9	adjusted 58:2
able 16:11 17:17 19:15	acknowledge 91:20	Administration 1:18
41:5 50:7 60:11 66:11	127:17	2:12
66:14 67:18 118:10	acknowledges 114:9	Administrator 2:16
123:4 133:10 135:11	acknowledging 91:9	admission 9:22 10:2
136:2 137:8,17 140:9	128:5	93:15
141:1,13 142:14	acknowledgment	admissions 11:11
144:22 147:15 156:8	125:21	156:6
179:8 183:9 191:21	ACO 140:6 167:20	admitted 92:21 115:18
193:1 195:8 198:7	ACOs 167:13	160:22 192:13
199:2	ACS 75:10	ADT 192:11 196:15
above-entitled 102:16	act 74:2 161:8 175:16	adult 54:21 58:7
absolute 127:7	182:9	adults 105:2
absolutely 48:17 55:9	acted 66:16	advanced 24:18 32:19
130:16 160:1 194:7	action 50:4 105:9	168:17
academy 149:4 190:17	actionable 50:7 114:22	advancement 128:16
accelerated 201:4	actions 26:22 52:10	Advantage 140:6
acceptable 142:12	105:9	adverse 23:7 82:17
accepted 134:9	activated 65:20	98:19 99:1 126:8
access 38:5 49:10 51:4	activation 160:15,16	128:19
61:3 66:2 71:8 89:2	161:5	Advocacy 1:19
93:9 118:10 120:11	activations 22:10	advocate 140:13
120:21 122:9 141:2	activities 173:5	affiliations 180:22
142:3,5,9 143:7 144:9	activity 14:8	afford 38:6 85:20 89:1
144:12 145:18 147:1	actual 67:11 91:12	184:14 185:8,11
159:6 170:2 190:16	acute 56:6,21,22 57:2	afternoon 101:2,4
accessed 117:8 120:15	58:7,22 65:18 66:4	128:3 134:18 155:5
122:8 185:20	92:16 129:1,12,17	age 20:8 63:12 132:11
accessibility 21:22	130:6 156:20 157:11	175:15
26:13 71:5 106:15	157:13 163:6 165:2	Agency 169:21
accessing 117:2 140:7	165:18 166:3,15	ages 174:8
142:20	168:11 176:22 177:3	Aging 2:7 169:21
accident 141:10	177:6,11,15 178:2,8	ago 31:2 157:6 192:5
accomplish 102:5	178:18 179:4,7	agree 19:13 24:13 59:3
155:1	acutely 57:12	59:17 113:13 116:12
accomplished 115:22	Adam 50:14	132:1 139:2 142:8
accomplishment	adapt 45:20	164:13 166:5 176:3
124:18	add 67:1 75:7 78:11	176:17,19 186:5
account 113:4 115:17	79:6 90:9 115:8 119:9	agreed 35:19 105:20
accountability 7:12 8:4	128:13	177:1
11:19 12:2 46:13	added 81:19 132:10	agreement 38:4
74:14 97:2 100:17	adding 30:4,4,16 35:14	ahead 15:14 26:5 28:8
126:17 127:3 150:3,7	addition 60:17	49:13 82:6 134:13
150:13	additional 58:18 105:9	146:3,7 199:12 201:7
accountable 74:16	105:10 129:3 133:13	201:22
118:6,13 126:19	203:6	air 156:1 201:7
182:9	address 52:2 97:4	alarm 188:18
accuracy 7:22 25:1	113:22 114:19 149:19	alcoholism 181:5
108:5	171:9 173:19 186:3	Aleesa 1:21 61:22 67:1
	191:13	76:11 85:8 141:18
		142:7 162:4 186:6
		alert 187:1 192:5,11
		193:7
		alerting 23:20 192:1,3,6
		alerts 190:7 193:11
		align 179:10
		aligned 178:16,17
		alignment 70:22 71:3
		alive 200:2
		allergies 187:1
		alleviating 154:14
		allow 41:22 44:21 116:5
		128:8 145:10
		allowing 127:9 171:12
		allows 168:8 190:9
		alteration 172:12
		alternative 168:22
		alternatively 108:12
		Amanda 187:15 196:20
		ambulance 109:1 138:9
		ambulances 162:22
		ambulatory 114:13
		Amen 115:6
		amenable 26:10
		American 40:13
		Americans 175:16
		amount 69:10 70:17
		106:13 129:19 133:11
		145:12 170:11 190:2
		amounts 194:22
		amplify 30:19
		Amy 2:8 38:9 82:7
		98:16 126:5
		analog 33:17 187:13
		analyses 182:11
		analysis 115:15 116:3
		Analyst 2:19 3:2
		and/or 95:15 100:15
		Andrea 2:2 142:6 192:2
		anecdotal 203:1
		aneurysm 164:5
		angst 114:16
		ankle 63:17
		answer 86:3 91:21
		165:10 184:15
		antibiotics 90:2 91:17
		116:6
		anticipated 130:8
		anticoagulation 88:13
		88:15 90:4
		antipsychotics 50:11
		anxiety 34:1 35:8 52:12
		154:15
		anybody 109:10 139:3
		200:8
		anybody's 202:4
		Anymore 37:1
		anyway 136:16

anyways 26:7
APM 168:18
APM's 151:12
APN 1:21
apologize 199:11
apoplectic 180:10,12
appeared 92:20
applied 11:5,10
applies 151:3
apply 10:3 36:1
appointment 157:4
 165:11
appreciate 51:13 99:16
 100:6 206:9 207:5
approach 43:10 111:13
 130:2 131:1 150:12
 196:13
approached 195:19
appropriate 14:14 41:6
 50:13,15 65:11 73:3
 80:20 81:12 96:20
 131:9,14
appropriateness 37:20
approve 157:16
April 1:6 202:15
architecture 164:20
area 16:9 25:2 98:6
 116:17 117:8 169:21
 195:18
areas 5:16 33:2,13,22
 65:1 98:10 102:15
 139:21
arena 55:5
Arjun 2:10 40:7 42:15
 55:10 59:19 61:11
 63:5 69:20 77:17
 78:15 86:10 127:22
 128:11 130:16 133:4
 136:4 149:5 164:7
 174:2 193:12 197:15
Arjun's 66:8 84:1 90:8
arrangement 167:22
arrive 9:16
arrives 24:19
arriving 98:3
arrowhead 206:21
artificial 14:11 15:6
aside 167:6
asked 30:10,12 77:22
 93:20 94:4
asking 43:11 74:3 77:8
 93:21 151:21
aspect 38:20 141:7
aspects 34:4 111:15
 188:12
aspiration 186:19
aspirational 119:16
 127:5 137:2 161:18

aspirationally 127:13
ASPR 205:21
assembling 202:19
assess 26:11 44:9
 118:15 121:15,18,19
 121:20 123:7
assessed 114:19 122:3
 122:6
assessing 112:2,8
 116:1
assessment 34:7,10,17
 36:9,15 39:19 51:12
 51:16,21 54:2 57:5,7
 62:2 69:21 121:13
 124:9,18
assessments 23:22
 43:13 73:20 182:10
asset 191:20
assigned 161:20
assist 123:4
Assistant 2:10
Associate 2:8
associated 53:18
Associates 1:13
associations 181:1
Asst 2:3
assume 65:17 123:19
 186:11
assuming 11:20
assumption 34:13
assure 174:6
asthma 10:6,12,16 50:4
 62:11 182:17
atrial 88:12
attack 176:20 177:3
Attending 2:2
attest 206:5
attribute 83:20
availability 37:21
 120:11 191:3 195:2
available 43:21 51:2
 117:2,6 120:14 121:7
 121:11 122:7 124:16
 144:1 158:22 165:12
 170:1,3,5 183:22
 188:5 203:4
avoid 61:1
aware 148:7
awfully 82:13

B

B 46:14 98:7 188:9
back 4:12 5:4 6:3 17:8
 27:6 36:8 38:2 39:16
 39:22 43:14 44:16
 46:9,15 47:9,10 51:17
 60:7,11 61:3 62:16
 65:10 69:16 72:13

73:22 74:13 77:14
 78:15 80:8 83:1 90:3
 90:10 91:1,13 92:4,10
 93:8 95:6,9,20 100:9
 102:1,10 107:17,17
 108:19 109:3 110:12
 112:22 113:15 119:8
 119:22 121:9 122:20
 125:13 126:12 127:2
 127:12 130:20 131:10
 131:15 132:17 133:12
 134:7 137:13 148:5
 149:10 151:7,13
 155:9 162:5 163:15
 165:1,14 170:15
 173:13 174:1,5 185:5
 185:16 190:13 192:21
 200:18 204:17
back/teach 38:2
background 85:10
backs 6:4
bad 54:16 68:22 131:2
 154:7 180:21
baked 78:22
balance 178:22
balancing 139:9
barrier 136:14 137:17
barriers 51:16 136:10
 139:4 140:5 182:20
 186:9
base 99:18
based 12:22 20:7 40:10
 40:20,20 44:15 53:21
 54:1,19 55:12 77:19
 160:20 194:10
baseline 54:13,20
basic 7:18
basically 6:20 7:16 9:6
 9:10 10:8 16:19 25:13
 31:9 132:6 156:12
 157:1 171:15 191:12
basis 88:11,18 148:3
Beacon 189:18
becoming 59:2
bed 27:6 29:9 107:17
began 191:12
behalf 205:21
behavioral 15:17,19
 16:2
believe 33:3 114:4,17
 147:9
belong 97:3 153:19
belongs 14:5 24:10
 98:13
bend 75:13
beneficiary 58:4
benefit 197:9
benefits 152:21 153:1

188:14
benefitting 196:1
benzodiazepines 87:13
best 44:20 45:10,17,17
 45:17 84:2 185:2
bet 81:6
better 17:17 26:18 58:9
 59:18 68:8 71:16 72:6
 73:5 104:3 107:11
 109:15 123:4 138:7
 140:15 150:14 151:8
 157:16 161:22 185:13
 204:13
beyond 61:18 92:2 99:4
 130:10
bidirectional 190:4,16
big 30:8 68:1 83:16
 85:22 86:1 103:18
 158:2 173:8 188:14
bigger 90:6 122:14
biggest 84:5 90:10
 137:3
bill 68:12,16
billing 196:18
bills 196:7
Bipartisan 140:2
bit 5:9 7:20 23:9,12
 30:19 47:19 70:4
 71:16 77:15 84:16
 98:18 99:10 103:11
 104:10 105:13 106:19
 106:22 107:1,19,21
 108:5 123:12 135:8,8
 135:9 136:20,22
 152:17 169:3 171:9
 185:6,6 188:10,13
 197:13 200:21
blanket 55:21
block 42:2 137:7
blood 21:10 62:13
blow 10:14 180:9
blown 70:5
burned 161:15
born 174:4
Boston 2:9
bottom 181:22
bounce 60:7
Bouncing 141:19
box 82:13 91:5 93:11
 148:2 149:2 188:21
box-checking 149:5
boxes 86:6
bracelet 187:4
bracelets 187:1
breadth 185:4
break 4:11 103:13
 141:9,14 142:18
breakout 4:10 6:1 18:7

33:10 47:10 99:14
100:7,9 101:1 102:5
203:11
breakouts 6:2
breath 57:9 63:21
Brenda 2:7 34:19 64:6
66:5 88:19 93:18
140:1 173:22,22
174:1 176:2
Brendan 97:21 205:22
206:7
bridge 116:13
brief 102:11,21,21
brighter 75:15
bring 69:16 91:17
152:18 170:17 181:1
201:12
bringing 30:22 153:6
169:10 180:14
brings 77:14
broad 10:14 12:6
137:15
broadband 156:18
broader 4:7 26:19
70:15 75:6 85:2 87:7
97:14 109:6 111:7
112:14 117:19 118:4
191:15
broadly 104:19 205:13
brought 67:1 105:8
109:10,12 112:13
136:4
Bu 86:7
bubbled 205:5
bucket 90:6
budget 174:11 194:17
build 48:13 59:7,9,11
98:17 128:1 158:2
169:2 185:6 188:11
189:20 191:18
building 42:2 160:12
161:2,17 190:5
built 25:7 57:19 123:11
155:13 167:7 174:13
178:6 182:4 188:5
bullet 150:4
bummed 180:20
bump 152:9
bunch 33:16 73:9
bundled 167:13
burden 21:3 32:13,14
55:7 56:1 67:5 69:14
81:12 151:2,15
158:18 174:20 175:4
burdens 40:21
burdensome 118:22
121:20 143:5
bus 155:11

business 2:14 194:1,11
194:17 195:6,21
197:1,2 198:13
button 85:13
buy 196:10

C

C 46:14,15 94:21
100:20 102:1
C's 100:10
C-O-N-T-E-N-T-S 4:1
CAHPS 113:19
California 191:8
California's 136:20
call 51:6 60:11 61:3
165:9 205:2
called 27:5 54:1 151:14
156:14 190:8 191:8
calls 138:9
cancer 163:15
Cantrill 1:9,11 4:2 5:3
26:3 28:4,20 31:19
34:19 35:21 36:11,20
37:2,14 38:9 39:15
40:7 42:15 44:7 45:5
47:17 49:12 54:4
55:10 59:19 61:10,22
63:1 64:6 66:5,20
70:3 75:9,22 76:11,19
77:11 82:7 83:6 84:4
85:7 86:9 88:9,19
89:6 90:7 91:3 92:6
93:18 94:6 98:16 99:8
102:14 108:14 109:16
109:20 115:9 116:21
117:14,18,21 123:8
125:4,8 130:16 131:4
131:21 132:18 133:15
133:18 134:4,16
140:17 193:4 195:10
200:20 201:1,14
205:17 206:13
capabilities 17:16
188:5,15
capability 59:13 187:18
capacities 17:15
capacity 96:4 156:19
157:10
capita 175:12
Capitation 151:13
caps 175:12
capture 34:6 42:1 43:3
46:22 97:5 100:18
114:18 129:5 162:14
179:8
captured 46:4 123:3
capturing 122:13
card 68:12

Carden 1:13 111:3
115:5 116:12 160:5,6
160:10
cardiology 155:12
careful 55:6 131:11
carefully 30:14 113:22
carer 111:20
carrier 119:13
carries 191:11
carve-outs 178:19
case 51:3 52:10 60:8
85:20 150:16 155:13
156:3 159:17,21
160:2 178:11 192:6
194:1,3,11,17 195:6
197:1,2 198:14
cases 18:21 33:8 106:5
131:10
CAT 163:11 165:13
177:19
catch 69:22 148:8
176:7
category 137:16
cath 22:9
catheters 6:6
caught 110:16
cause 179:7
causing 76:10
caution 185:7
CCM 1:12
CEDR 198:5
ceiling 110:3
cell 16:6
center 1:11 2:12 3:3
18:18 19:5 140:3
155:22 156:1 168:12
centered 39:8 148:8
centers 17:11 22:14
27:11 162:12 170:14
central 103:22 110:20
Century 153:22
certain 14:7 27:9 43:15
51:2 54:20 69:22
85:15 98:3 147:1,1
187:12 190:2 194:22
201:5
certainly 17:6 25:11
27:12 59:22 69:7
81:18 89:14 110:5
114:15 193:6 205:19
certified 41:8
cetera 8:1 43:18
Chairman 189:22
challenge 21:5 36:5
56:15 75:21 84:6
159:10 193:21
challenges 26:5 35:22
198:3

challenging 34:8 55:18
57:17 84:12 85:1
119:2 139:11 176:15
Chan 190:1
chance 153:14
chances 112:7 113:8
change 11:16 41:7
73:13 79:8 81:19,20
88:4 123:20 135:7
153:9 168:1,5 172:20
175:3 194:14 197:4
200:15
changed 86:8
changes 5:6 103:19
110:6 135:12 136:2
138:10 140:13,14
175:8,8 204:21
changing 5:8
characteristics 20:8
characterization 154:9
charging 152:2
chart 76:22
check 13:9 20:20 70:4
82:13 91:5
check-in 105:4,5
checkbox 66:17 86:2
checkers 149:3
checking 104:20
checklist 20:3 104:9
chest 36:2,21 114:7
172:7 177:3
chiefs 180:10,11
Children's 2:9
chime 111:2
choice 181:11 196:10
choose 142:14
choosing 144:8 188:7
chronic 10:16 16:5,6
21:7 52:16 54:11 57:1
58:22 59:1 65:9 122:2
122:4 130:9 132:11
154:17 156:21 157:13
175:17 177:9,10
180:13 181:4,14
chronically 160:17
circumstances 116:4
citizens 31:5
city 1:15 44:14 49:11
138:6 153:16 180:3
clarification 5:20 60:12
82:9
clarify 60:20
clarifying 40:4
clarity 100:11 102:1,2
clean 100:20
cleaning 102:12
clear 5:19 80:5 101:10
131:9

clearance 180:15
clearly 20:6 58:17 98:6 171:18
click 85:13
clicking 148:2
clinic 2:17 90:4 157:5
clinical 1:21 2:3 40:14 56:13 84:11 86:19 106:11,12 185:18 194:2 198:5
clinician 194:3,6 198:15
clinicians 167:18 168:14,14 198:11,21 199:1
clinics 159:3
close 38:2 74:21
closely 28:16
closer 8:8
closing 108:20
cloud 147:14
clueless 77:1
CMMI 118:12
CMS 40:15 136:7
co-chairs 1:9 13:21
Co-Director 2:12
coach 160:19
coached 161:13
coaches 171:21
coaching 161:15
Cobb 2:18 4:5 26:6 27:2 27:14,22 31:22 34:20 35:3,16,19 36:8,14,19 36:22 49:14 52:21 55:9 69:2 109:22 115:2,6 187:8 202:3
codes 105:11 178:22
cognizant 115:21
Coleman 79:17 80:9 160:20
collaborative 150:6 182:7
collaboratively 105:20 153:17
collaboratives 182:15
collapsed 38:15
colleagues 102:4
collect 41:16 121:3,17
collected 29:21 43:16 95:12 123:3
collecting 42:21 78:16 125:1
collection 40:22 41:8 41:14 92:14 93:4 120:10,13 124:5,20
College 40:13
colonoscopy 147:20
Colorado 1:12

combination 63:11
combined 7:11 196:8
combining 7:8
come 15:4 20:15 36:16 41:4 62:16 67:9 73:7 76:14 82:9 90:11 107:12 113:15 117:12 128:3 130:20 131:10 133:12 134:7 144:11 148:4 151:2 163:14 167:2 181:3 186:4 192:9 204:2,17
comes 16:13 19:18 30:5 46:13 48:20 67:6 68:2 88:11,17 89:21 91:1 121:21 127:12 128:14 137:13 148:11 151:4,4,5,6,21 168:4 188:20 192:12
coming 9:12 12:9 47:1 64:20 65:9 94:18 116:20 119:8 122:20 126:22 131:15 138:21 151:13 156:15,21 162:7 190:21 206:1
Command 155:22 156:1
comment 4:13,17 29:15 37:11,15 47:5 54:5 75:10 76:3 97:5 98:18 126:5 134:1 184:13 199:6 200:12 204:5,7 204:13,19 205:9
comments 26:3 28:21 37:1 40:10 66:8 76:1 108:15 109:18 115:10 117:15 123:9 125:5 133:16 134:2 140:19 146:9 197:11,14 199:4,8 201:19 204:17,20 205:4,6,15
Commission 1:17
committee 20:16 109:3 126:21 136:17
committees 42:17
common 9:5 22:10 30:21 73:16 114:7 125:12 137:7
commonalities 47:20 48:16
commonality 5:17 186:15
commonly 11:10
communicate 79:3 92:5 118:11
communicated 39:6
communicating 29:7
communication 4:4,6

6:10,19 14:15 16:21 29:3,14 31:20 33:21 33:22 34:15 35:8 37:5 40:11,17 41:18 42:7 42:10 43:9 44:16 51:8 52:4 53:11 60:17 65:15 67:3 69:8 71:18 71:21 72:15 90:11 91:2 105:17 109:21 110:4,10,14,19 111:14 112:10 113:21 115:11 119:21 124:6 124:12 135:18
communications 72:9 124:22
communities 48:18 189:19
communities' 122:18
community 4:7 15:9 24:11 26:15,19 27:1 27:12,17,20 28:1,10 28:14,16,17 31:13 39:22 40:6 43:17 44:20 48:12 58:21 70:16 73:17 74:8,19 75:6 85:2 88:16 92:11 97:9 107:9,10 116:14 117:19 118:5,9,9,13 118:16,21 119:3,11 119:17 121:11 123:1 123:4,6,11,11,16 125:2 156:11 157:8 158:16 159:12 161:14 169:14,15,20 170:19 170:20 171:4 175:1,5 176:10,14 181:2 182:10,17 184:6 196:1
community-based 75:19 137:6 140:8 174:9
community-dwelling 105:1
comorbid 20:9
comorbidities 16:6 20:7 63:16
comorbidity 63:12
companies 184:18
compare 155:21
competence 200:9
competency 69:9 113:5
complete 193:10
completed 23:22 74:2
completely 154:22 174:13
completing 118:20
complex 114:11 164:4 191:12

complicated 193:3
components 39:5
comprehensive 22:14 27:11
computer 143:8 146:10
concept 13:2 20:2 21:6 30:4 43:15 56:17 87:6 96:8 100:12,18 101:10,11,15,19,21 103:10 104:18 118:3 138:12 158:3 177:9 182:8 192:3,11
concepts 4:10 10:13,22 11:2 12:15 15:13 16:18 20:1 23:5 26:9 26:12,18 45:18 52:18 52:22 53:3,5,7 73:7 74:5,18 81:3 94:8 101:7,10 102:2 103:4 103:9 126:9 157:14 202:21
conceptual 164:21
concern 91:5 98:2 112:8
concerning 115:10 125:6 133:16
concerns 35:6 112:2 113:1 114:1,18 141:6
concluded 134:18
concrete 42:11
condition 10:17 116:1 122:2,4 132:12 154:12
conditions 20:9 21:15 52:16 54:12 56:13 65:9 130:9 157:13
conducting 73:20
conduit 125:2 196:5
Conference 1:8
conferences 23:17
confirmation 37:22 112:16
confirming 78:3
connect 44:4 120:1 153:3
connected 47:15 88:15
Connecticut 174:4,5
connecting 26:16 121:8 121:9
connection 70:21 71:2 105:6
connections 28:12 72:3 74:15 182:4
connectivity 31:12
consensus 23:17
consent 33:5,8,14 71:4 124:6 137:8
consequence 174:17

consider 20:17 27:19
 30:14
considered 76:5
considering 35:10
 54:10
constitute 132:3
construct 56:10 58:9
Consultant 2:20
contact 144:11 189:12
context 29:1 84:11
 201:15
continue 69:13 206:10
continues 162:20,22
continuing 93:1
contracting 173:3,4
contribute 196:11
control 155:22 156:1
 157:12 201:8
convene 168:16
convenient 165:3,4,5,6
 165:17
conversation 32:8,13
 33:4 76:4 97:7 99:12
 103:2,7 110:8 111:1
 199:15 202:22
conversations 73:10
 73:22 95:21 111:6,18
coordinate 140:15
 156:20
coordinated 16:14
 177:21
coordinating 171:20
coordination 3:3 10:6
 58:18 59:18 66:10
 117:10 129:7 130:1
 130:12 133:14 151:10
 165:1 168:10 169:22
 171:17 172:9 173:5
 173:19 177:8,11
 178:3,9 179:6 180:1
 191:11 195:6 197:20
coordinators 177:17
COPD 173:11
core 47:6
Corporation 2:2 68:2
Corps 99:18,19,22
correct 40:18 144:13
 186:13
cost 61:19 79:11 97:8,9
 179:2,20 180:6
 184:13 185:10,20
 186:1 188:2 196:2,9
 199:21
cost-effectively 155:19
costs 97:7 138:20
 140:11 157:15 185:14
 186:9,10
couching 131:12

counter 32:21
countless 156:6
country 146:14 167:19
 167:21 175:22 201:3
 201:8
County 2:3
couple 5:6 6:21 33:11
 71:11 90:5 111:7
 120:5 125:13 146:8
 164:12 166:2 178:13
 183:1
coupled 122:7 157:8
course 160:8,9 185:11
courts 181:7
cover 67:17 152:3
covered 185:22 188:1
CPC 151:12
CPCI 168:21
CPHQ 1:16 2:14
crafted 205:7
crazy 81:9
create 21:3 43:12 65:1
 164:19 182:5 195:3
 198:14
created 95:22 163:2
 178:21
creates 21:2
credit 68:12
crisis 112:2 161:9
criteria 10:18
critical 29:13 49:9 51:7
 92:17 114:4 124:20
 125:22 139:10 190:15
critically 56:5 57:12
cross 24:8 26:10
 132:16
CRT 193:8
cultural 69:9 113:5
culturally 35:11
curious 27:16 28:2
 32:17 34:17
currency 201:9
current 70:17 172:16
 176:17 194:8 198:13
currently 162:2 198:12
customer 68:2
cut 175:12
cuts 174:11,12
cutting 24:8 26:10

D

D.C 1:8
da- 172:7
da-da 172:8
dangerous 200:19
data 22:1 26:14 30:17
 32:9 40:14,21,22 41:8
 41:11,15,17 42:1

61:12 63:10 64:5
 77:20 78:17 84:2,9,13
 106:16 108:2 138:1,4
 138:17 141:20 142:2
 144:21 145:3 146:14
 146:17 147:10,12,13
 147:22 186:14,15
 198:6,9,11,15,17,19
 199:2
database 30:9
date 204:8
dates 202:12 203:15
 205:11
David 157:5
day 4:2 6:7 94:3 111:16
 121:6 157:2 177:1,4
 177:14 199:22
daylight 101:2
days 29:11 31:17 59:1,7
 59:16 62:12 68:10
 87:5 90:19 110:9
 111:7 129:12,17,19
 130:7 134:22 161:11
 163:10,10,13,16
 202:19 203:2,10
deadening 193:10
deal 88:11 199:22
dealing 156:4 181:18
deals 148:21
decade 169:1
decades 155:11
decide 44:20 145:4
 146:19
decided 105:19
decision 34:5 35:12
 69:8 112:22 113:3,8
 113:18 114:21 117:10
 143:15
decisions 98:8 105:12
decrease 147:22
deceased 161:16
default 144:10 169:11
defender 181:9
define 4:10 61:7 121:18
 163:18
defined 10:7 20:7 58:15
 132:21 165:3
defining 64:2 74:7,9
 103:22 106:10 108:1
 133:7 154:15
definitely 135:16
 141:13 145:19 175:2
definition 7:15 8:3 35:4
 40:4 47:12 101:12
 106:8 145:14 158:17
 162:13
definitions 27:15 49:20
 145:16

degree 5:10 130:17
delays 99:3
deleted 103:9
deliberate 34:16
deliver 22:17 48:6
 166:6
delivered 178:5
delivering 24:21
delivery 46:20 174:21
demand 163:2 174:14
 175:3
demographic 41:8
 78:17
demonstrated 16:1
 191:6
demonstration 118:13
denominator 101:14
Denver 1:11
depart 134:17
department 1:3 2:9,11
 8:20 9:5,13,22 10:1
 11:13,22 12:10 13:15
 15:19 16:4,13 17:4,7
 17:13,16 18:3,17 19:8
 23:2,14 24:20 29:19
 30:7 47:2,3 48:12
 57:2,6,11 63:14 78:2
 78:7,10 86:22 87:4,12
 87:17 93:4 94:19 95:9
 95:17,18 96:1 98:7
 105:21 107:20 111:21
 112:18 113:16 114:5
 114:8,20 116:9 119:1
 120:19 129:2,4,20
 130:7 133:13 153:21
 154:4,9 155:3,14
 156:11 158:9 160:18
 161:21 162:14,20
 163:3 164:15 166:12
 168:11 169:19 171:12
 173:3 176:21 177:17
 178:11 179:21,21
 180:4 181:8,8,21
 191:16 197:21
department's 191:1
departments 30:22
 31:6 44:13 45:1 104:2
 154:21 157:21 180:9
 180:14 181:9,17
 197:22
depend 199:19
dependent 26:22 27:12
 37:6
depending 85:12 126:1
 126:1
depends 37:11 54:2
deploy 16:11
deploying 198:4

design 2:5 154:6
designating 35:22
detail 5:10 21:20 22:7 107:3
detailed 38:7
details 108:9
determinants 23:7,18 29:16,19 43:12,19 51:19 73:21 107:6 113:6 174:18 190:19 191:2
determine 57:11 62:7
determining 116:1
develop 10:14 25:3 40:15,16 41:5 83:13 87:9 101:19 152:17
developed 40:19 45:18 53:7 80:10 129:10 162:11 189:15
developer 2:14 101:18 101:20
developing 19:14 20:17 78:12 105:15
development 16:9 43:5 106:10
diabetes 57:9
diagnosis 19:2 21:17 49:4 62:20 63:13
diagnostic 19:12
diagnostics 165:20
dialog 135:7
dialysis 200:4
dictated 111:17,18
Diego 1:15,15 99:17,19 100:3 137:22 138:6 181:5 189:18
diet 72:21
differences 38:12 159:22
different 5:11,16,17 9:2 12:8,22 14:18,22,22 16:22 17:1 20:18,19 33:16 35:18 39:9 44:13 46:5,7 48:17,18 48:19 51:21 52:7 53:16,17 56:9,13,16 63:11 71:18 72:5 74:11 78:4 79:5 80:19 106:12 110:10,11,11 110:12 116:10 123:15 123:18 126:2,3,7 135:15,18 137:14 142:17 145:16 148:10 152:17 164:2 178:14 180:6 189:14 196:12 197:22 204:14,14
differentiate 17:17
differently 195:19

difficult 83:16 176:16 183:22
difficulty 84:7 127:10
digging 123:12
digital 2:1 33:17
dinner 6:16 151:19
direct 119:17 157:12
direction 175:9
directions 179:12 203:6
directives 24:18 32:19
directly 7:3 8:15,22 12:13 17:5 29:1 103:4 133:12
director 1:15,16,19,20 2:1,7,8,9,11,15,18 3:1 153:16 157:6
directory 196:16
disagree 142:10
discarded 75:11
discharge 12:19 23:8 37:22 38:3 50:4,6 52:12 53:12,15 57:14 57:15 58:16 60:10,14 62:3 63:13 73:3 79:4 91:7 93:16 104:11 129:13,18 189:3
discharged 13:13,14 40:5 49:22 60:16 160:17 161:1
discharges 104:12,21 129:11 132:21
discrete 84:13
discuss 106:7 203:16
discussed 16:17 49:19 53:9,17 76:3 77:19 84:7 130:17
discussing 36:2 87:2
discussion 4:15 5:14 17:21 23:9 33:7 94:9 96:10 103:18,20 108:4 111:8 112:15 114:16 126:18 128:4 134:15,17 135:22 136:12,17 145:20 161:17
discussions 13:4 25:15 112:13
disease 16:6 58:22 59:1 117:4 171:21 175:18
disease- 106:18
diseases 21:8 156:20 156:21
Disney 68:1
dispatched 70:9
dissecting 184:8
distinction 131:18
Division 2:16 3:1,3
doable 42:11

doctor 10:10 11:6,20 17:22 67:7 77:1 133:11 143:22 146:19
doctors 147:12 148:3 156:22
document 124:7
documentation 36:6 71:3 142:19
documented 13:3 53:11 60:17 72:11,19
documenting 72:8
documents 120:3
dog 186:21
doing 5:8,21 7:6 36:17 36:20 39:19 42:3 56:14 78:2 82:12 84:1 92:22 101:22 110:21 115:16 137:21 148:13 149:11,18 150:12 151:22 158:4 159:13 162:2 187:10
dollar 151:20
dollars 166:10 176:12 176:13
domain 7:8 14:7,11,12 14:17,20 15:2 26:10 51:8 55:15 71:17 72:15 79:10 80:15 97:4,8 100:15,19 110:14 117:16 125:9
domains 5:16 14:10 15:1 79:8,9 100:12,18 103:3,5 110:20 137:8
Donna 1:13 110:1,3 111:2 115:2 160:5,6
door 121:21 155:9,10 181:17 202:5
dosage 81:20
doses 84:21
dots 26:16
downtown 182:2
Dr 4:4 6:15 13:19 15:15 17:20 18:8,9,13 24:6 24:9,13 26:20 27:3,21 30:3 37:17 45:7 47:18 52:20 63:2 77:16 78:14 82:22 83:8 94:7 99:6,9 102:19 103:17 125:11 128:20 129:8 131:3,7 132:19 172:21 204:4 206:22
draft 202:13 204:5,6 205:7,12 206:11
drain 154:18
dream 153:16
drive 187:3,12 192:20
driven 158:5
drives 51:18 81:9

driving 76:8
drug 87:19 90:12,13,17 90:18,18 126:8
drug/disease 89:15
drug/drug 89:14
drugs 90:17 184:14
due 122:15,15,22 181:22
Duke 1:18
DUNFORD 1:14 30:18 75:17 108:16 109:5 115:12 116:15 132:1 137:1 153:13 162:18 179:17 189:17 206:15
uplicated 9:18
duplication 147:22
uplications 89:13
Durham 1:18
dying 200:1
dynamic 190:22

E

earlier 34:11 74:14 78:15 97:7 136:5 138:5 150:5,21 172:22
early 45:4 170:4
ease 200:21
easily 78:22 143:3
east 206:17
easy 41:20 78:8 84:10 114:2 143:20 144:2 170:18
eat 134:9
echo 61:11 84:7,15 92:7
echoed 196:21
echoes 119:18
ED 2:11 4:16 9:14,14 12:16,19 13:3 16:2 17:22 24:1 27:18 28:18 29:2 30:5 36:6 43:11,17,22 44:22 46:14 54:10 55:5,22 56:20 57:20,20 58:3,4 58:8,10,16,21 59:5,10 59:16,22 60:19 61:8 65:11 66:9 75:14 76:5 76:8,10,14 86:14 88:3 88:12 91:18,21 92:16 98:3 100:5 104:11,14 107:6,8 114:10 116:9 116:19 118:20 119:16 120:9,12 121:5 127:6 127:12,15 128:17,18 129:5 130:10 131:2 131:11,13 132:13 147:19 148:5 154:7

155:10 160:19 161:1 161:4,8 162:1 164:9 166:1 170:9 171:18 172:4 173:3,8,12,18 173:18 179:12 185:18 187:11 192:14 198:1	Emeritus 1:14 employees 167:18 employer 61:13 empowered 65:21 empty 176:10 EMR 147:12 149:8 188:12 189:2,14 EMRs 146:16 187:17 188:15 EMS 1:15 2:3 22:5 26:11,12,20,21 27:16 28:4,10,16 29:1,9 106:13,14,19 107:14 107:22 108:1,2,3,17 108:19 157:10 190:3 192:8 EMTs 74:10 en 184:10 192:8 enable 183:15 enabler 183:5,13 encounter 22:1 26:14 72:20 encourage 188:12 205:10 encouraged 78:17 ended 7:6 53:2 endorsed 83:9 191:10 ends 11:17 88:12 150:16 enforcement 31:4 74:10 109:7 engage 118:20 119:13 139:12 181:15 engaged 162:1 206:4 engagement 4:7 15:10 26:19 70:15 71:4 107:9,10 117:18 160:15 161:16 engages 161:4,9 engaging 75:5 118:4 161:22 engender 5:13 enhance 95:15 enjoy 148:13 enjoyed 206:18 enrolled 124:11 ensuing 161:11 ensure 120:10 ensuring 72:10 74:22 enterprise 78:11 entire 191:17 entities 162:16 environment 111:22 112:5 119:3 128:2 135:11 Epic 2:14 episode 111:10 165:2 179:7	episodic 18:15 equal 95:22 equally 124:13 equivalently 169:3 ER 90:19 141:13 147:1 156:2,22 158:2,15 162:9 188:21 192:8 200:6 Eric 79:17 error 82:15 83:4 errors 83:20 99:2 126:8 especially 29:8 30:15 92:17 100:11 150:21 204:14 essence 112:1 114:3,17 essential 156:12 essentially 202:14 et 7:22 43:18 Evaluation 2:5,13 event 6:18 58:8 80:21 82:17 132:4 events 98:20 99:1 107:15 126:8 172:5 everybody 59:3,17 153:18 155:9 158:21 165:8,17 169:15 170:8 181:10 182:18 190:17 192:21 199:17 203:4,10 everybody's 78:1 115:2 202:5 everything's 85:13 184:10 evolving 112:21 113:17 exacerbation 56:22 58:22 exactly 32:9 36:13 67:13 example 8:17 11:18 12:2,3 81:1 88:10 103:8 109:7 122:20 173:7 184:17 191:9 195:13 examples 25:10 103:8 excellent 75:9 130:21 134:20 135:3 excess 129:11,21 130:10 exchange 140:20 141:20 190:4 193:15 195:1 198:19 excited 206:7,8 exciting 206:2 execute 119:14 138:10 140:1 executed 192:15 Executive 2:1 exercise 203:21	exhausted 93:13 exist 25:9,11 123:1,13 195:7 existence 70:18 existing 7:2 41:21,22 120:2 167:8,8 176:17 exists 29:4 118:8 184:6 expand 47:18 53:14 98:1,20 190:15 expanded 79:9 97:13 155:13 191:14 expect 44:17 58:3 expectation 128:22 expectations 17:1 68:6 expected 129:16 130:6 130:19 131:14 expensive 179:19 180:2 experience 2:1 18:6 69:3 79:14,16 80:12 94:9,11 95:3,3,11 97:12,13 108:13 115:12 159:20 expert 1:3,7 100:6 205:8 expertise 181:20 explain 114:1 explore 69:13 explored 162:11 exposed 43:20 express 134:19 expressed 73:2 expressing 144:20 extensive 5:5 6:7 extent 98:22 extra 152:5 extracts 146:17 extremely 71:14 eyes 202:5
F			
face- 151:9 FACEP 1:11,14 4:2 facets 86:2 facilitate 25:7 facilities 9:4 95:8,22 105:3 182:3 facility 10:4 95:10,16 99:19 120:9 fact 5:5 42:20 65:14,19 66:1 67:19 68:15,19 94:1,2 114:9 131:1 142:10 148:22 154:8 177:2 180:12 199:21 201:3 206:6 factors 54:16 63:12 113:7 Faculty 1:21			

fail 195:15
failed 113:14 131:16
failure 55:20 56:19
 57:10 62:13 63:15
 76:6 88:5 92:1 112:8
 121:15 122:15,22
 170:9
failures 169:22
fair 32:16 106:13
 109:16
fairly 88:18 103:1
 123:21
faithful 100:1
fall 23:21 27:5 91:13
 106:2 132:6,15
 161:16
fallen 132:7
falls 107:16 172:5
family 2:4 19:20 67:6
 79:15
fan 68:1
far 36:12 169:4 186:7
 201:7 202:18
fast 70:13
fastest 175:21
fatigue 188:18 193:7
fears 52:12
feasible 143:10 197:19
fed 95:6
federal 174:12
fee 64:10,18 196:16
fee-for-service 128:1
 155:2 164:20 167:10
 168:3 171:13
feed 69:3 190:11
feedback 7:12 8:4,10
 12:3 16:18,19 17:4,14
 17:20,22 18:3,6,10,11
 18:21 19:15,21 32:18
 49:15 50:17 67:19,21
 69:10 95:14 103:4
 105:14 106:6 108:17
 115:4 204:22
feeding 141:4
feel 75:7 114:14 142:21
 145:16 192:2 205:12
feeling 117:1 144:20
feels 57:8 82:13
fees 151:13 173:12
fell 72:14 161:13
Fellowship 2:12
felt 33:13 50:14 52:10
 72:6 80:20 111:9,16
 122:17 199:15
fi 99:22 100:3
fib 88:12
fiction 76:20
field 29:8 78:22 79:6

151:1 190:11 192:4
 192:10
fields 147:1
figure 44:4 62:22 75:13
 120:8 176:11
figured 67:1
figuring 155:4
file 190:8
fill 51:20 123:6
filled 85:21 189:5,9
filling 180:16
final 15:5 93:15 125:9
 203:19 205:1
finalizing 202:13
finally 25:13 34:7 74:18
 108:4 174:22
financial 117:10 127:21
 155:17 176:16
find 27:4 28:17 123:21
 131:17 137:10 154:10
 180:22 184:1 191:21
 200:16
finding 127:11 159:4
 171:22 184:8
fine 62:8
fingers 150:10
fire 28:13 179:21 180:9
 180:10 181:8
Fire-Rescue 1:16
first 6:9 9:21 41:13,16
 65:3 71:14 100:11
 102:1 112:9 120:7
 123:22 132:7 150:3,4
 165:10,11
fit 71:16 75:14 97:16
 154:1 166:3,20
fits 87:7 165:2
five 61:18 64:10 72:5
 73:4 154:11 166:9,10
fix 131:17 171:4
flagged 21:17
flags 188:22
flash 187:3
flavors 12:8
flesh 18:7 125:14
 188:13
fleshed 103:10
fleshing 99:5
flexibility 99:16
flexible 100:4,6
flip 56:4 58:20
Floor 1:8
Florida 1:14,20
flow 149:1,22
flows 41:21 78:9
fluid 110:16
flying 201:11
focus 55:19 71:17 72:8

73:5 74:6 82:12 86:7
 101:8 104:3 119:5
focused 23:18 61:20
 71:7 72:16 95:7 97:11
 118:6 126:8
focusing 80:13 107:19
Foley 6:6
folks 56:20 130:14
 187:11
follow 10:11 13:3,5,6
 14:3,8,10,14,18,20
 15:7 21:7,13,13 25:17
 25:19 36:6 37:7 38:5
 52:5,7,8,14 53:16,18
 54:10 55:22 56:3
 57:16,20 58:10,14,15
 60:5,13 61:4,5 62:4,6
 62:9,11,12,17 63:7,18
 66:12,13,16 72:20
 77:4 78:6 80:16,17,22
 81:4 91:15 96:6,10,11
 96:12,15,20 100:16
 104:18 158:12 193:16
 197:5 200:11 203:6
follow- 119:11 126:12
follow-up 104:16 122:9
 126:14,16 173:11
followed 44:17
following 23:22 54:7
 67:6 140:18
follows 103:19
force 156:1 168:17
 197:7
foreground 20:11
foremost 112:9
forever 85:16 145:11
forget 92:9
form 180:5
formal 36:15 92:22
format 42:1 146:17
forms 126:2
formulary 185:21,22
 188:1
forth 44:16
fortunately 189:21
Forum 1:1,8 126:21
forward 81:3 130:22
 131:6 206:9,11
found 5:11,12 49:17
 52:1 71:6,19 72:5
 86:5 122:19 137:13
 139:16 159:19 161:2
 161:7 183:5,22
foundation 1:19 123:10
foundational 139:16
 183:6,13
four 32:3 57:6,10 61:18
 79:8 192:5

fracture 132:9
fractures 164:3
fragmented 153:6
frame 53:20 58:11,15
 62:4 177:9
frames 53:18
framework 45:9 47:1
 98:11 115:15 128:14
 164:21
frankly 181:11
free 44:22 75:7 148:14
 159:6 205:12
freight 205:18
frequent 16:4 61:21
 88:18
frequently 16:14 19:10
 29:8
friends 188:13
front 91:9 148:18,19
 155:8 181:17
frustrating 128:18
full 74:8
fully 65:4
function 86:22
functional 97:15
fund 166:13
further 40:4 112:19
Furthermore 154:20
future 43:5 106:10
 116:10 132:4 158:5,9
 164:10 194:13

G

gap 29:4 66:22 67:4,17
 76:9 86:17 97:22 98:3
 98:6 178:4
gaps 5:12 24:15 69:6,6
 74:17,18 75:17 86:20
 87:20 88:2 96:22
 114:15
garden 100:21
gatekeeper 155:17,18
gateway 183:18
gather 95:2 184:22
gathering 98:12
gee 174:22
general 2:3 53:22
 107:13 128:22 146:9
generalize 42:16
generalized 130:22
generating 30:16
Generation 156:15
geographies 193:20
get-togethers 203:5
getting 21:7,13 22:18
 45:22 46:8 98:7 139:5
 148:5 151:8 169:17
 196:18 197:12

giant 157:14
give 6:5,10 17:14 18:20
 19:15 44:21 62:4,5
 85:9 90:20 100:10
 101:11 142:3 163:21
 168:4 188:2 201:15
given 12:3 157:11
 184:20
giver 79:16 93:12
giving 71:7 91:22
glass 141:9,14
global 45:16 125:18
 155:1 194:17
goal 23:3
goals 35:2,15 36:2 73:1
 73:3
gofer 149:5
gotten 38:19 68:12
 73:12
grant 187:2 189:21
 190:6
gray 33:13
greater 102:2
greatest 55:8 65:1
greatly 44:11
Gregg 3:1 205:22 206:7
gripe 197:18
grounded 103:2
group 4:10,12 6:1,9
 8:11 9:20 22:6 23:9
 24:4 26:1 28:1,2,5,5
 31:20 38:14 41:4
 44:14 46:11 47:12
 49:16 50:18 53:10
 54:10 56:11,18 57:13
 69:22 70:16 71:20,21
 71:22 72:7 73:8 75:7
 77:19 78:5 82:11 83:1
 83:11 98:12 102:22
 107:9,10 110:5 111:7
 112:15 130:4 132:2
 150:5 172:2 173:14
 173:18 203:5,11
groups 5:17 38:13 39:3
 61:13 70:17 72:3
 73:22 82:10 99:15
 111:10,19 135:16
 173:3,9 203:15
growing 157:7 162:17
 162:19 175:21
guaranteed 143:2
guess 8:7 27:14,22
 39:4 43:14 88:6
 145:13 163:21 193:13
 207:2
guided 106:11
gummy 100:4,5
gunshot 36:1,17 114:6

guy's 76:22
GYN 151:5

H

half 6:3
hand 65:16 109:7
hand-ringing 114:16
handed 6:13
handing 29:1
handle 44:20
handoff 31:9,10
happen 11:12 12:17
 64:1 96:2,18,20
 104:17 113:3,14
 126:16 127:18 128:8
 136:9 163:22 171:6
 184:16 195:8
happened 9:21 11:8
 17:12 18:1,10 64:9
 67:10 68:22 82:3
 90:19 125:14
happening 76:9 176:9,9
happens 41:10 47:2
 86:15 88:16 112:17
 180:2 184:15 204:16
happy 68:15 173:15
 202:3
hard 56:14 87:2 134:20
 181:16
harnessed 192:17
harsh 101:2
HASTINGS 1:17 54:6
 89:7
HCAHPS 113:20
he'll 132:17
head 88:7
headache 164:5
heading 150:4
heads 115:3 119:19
health 1:11 2:1,5,6,7,14
 2:15 3:2,2 15:17,20
 16:2 33:12 37:20
 41:19 52:15 54:13,20
 58:8 59:13 61:12
 65:22 73:21 75:18
 85:11 86:5 107:15
 112:2,8 140:19 142:2
 148:17 159:13 161:14
 167:13,21 171:20
 173:2 187:4 190:20
 198:4
healthcare 3:3 9:4
 28:15 32:6,7,11 79:3
 79:11 97:10 100:2
 137:5 140:11,11
 157:16 160:19 161:9
 169:13 174:20 195:7
hear 18:5 28:2 34:17

45:21 85:19 95:21
 139:14 202:5
heard 6:18 87:21 97:19
 112:14 135:17 150:5
 170:10 182:20
hearing 15:1 55:17 62:1
 80:3 117:12 125:12
 201:21
heart 57:9 62:13 63:15
 138:18 176:20 177:3
held 74:16 126:19
help 28:18 40:3,12
 43:18 45:19 75:5
 86:18 95:18 99:14
 101:20 120:1 144:1
 147:17 149:18 170:13
 172:15 184:22
helped 99:13
helpful 8:11 18:21 21:2
 82:21 103:11 188:6
 189:14
helping 44:9 149:18
herbs 32:22
HHS 3:2,3
HIE 141:5 189:21
 190:16 191:17 195:2
 195:19
HIEs 191:18 192:16
high 10:15 13:14,16
 15:18 16:3 20:4,5
 21:16 25:20 52:16
 53:3 55:19 56:19
 57:22 61:5 63:4 64:2
 64:10,17 69:14 73:11
 87:13 103:1,6 106:9
 106:11 110:7 111:1
 121:14 170:9 171:14
 188:20
high- 104:20 188:22
high-acuity 186:19
high-needs 138:19
high-risk 103:22 104:3
 104:7,8,12 107:14
 108:3 125:17 132:20
 138:18 140:16 172:2
 173:20 186:19 188:20
 189:3 192:7
higher 91:16 128:6
 173:6,12
highest 48:7
highly 37:6
highly-trained 159:12
Hill 136:7
hip 132:9
HIPAA 33:7
historical 93:14
historically 177:8
history 57:9 92:14 93:5

hit 127:7
HIV 138:15
Hofstra 2:5
hold 109:9
holistic 142:9
holistically 153:15
home 16:15 23:22 27:5
 29:5 30:10 39:22 40:5
 84:22 93:12 115:14
 115:18 116:4,5 143:8
 156:5,17,17 163:14
 204:2
homeless 181:5
homelessness 181:14
homes 17:11 137:12
 159:5
homework 28:1
honestly 83:2
hooked 76:15
hope 6:16 36:16 40:22
 99:13 110:2 112:20
hopefully 7:13
Hopkins 2:3
hospice 65:12
hospital 2:3 10:1 13:13
 22:1 43:18 48:5,12
 49:10,11 57:12 65:10
 106:16 124:13 129:10
 129:13,18,19 155:15
 157:3 158:1 160:4
 167:18,21 176:6,13
 182:1 194:11 195:21
 196:10 198:1,9,10
 199:2,21 200:3,5
hospital's 198:16
hospital- 194:9
hospital-based 168:7
 176:22 198:8 199:1
hospital-employed
 198:21
Hospital/Harvard 2:9
hospitalization 56:8
 57:13
hospitalizations 193:18
hospitals 22:16,19 31:1
 31:2 49:8 123:5
 157:20 167:12 168:6
 182:8 194:13 197:4,7
 198:21 201:2,7
hour 6:2
hours 10:9,10,12 22:3
 24:20 34:9 57:6,10
 104:13 105:4 121:5
 154:11
housing 138:2,5,7,8,11
 138:11 159:5
Houston 156:22 157:6
Howard 2:2

hub 166:15
huge 29:4 67:5 99:19
 137:7 194:2,13
hundred 22:16
hyperglycemia 59:6
hypertension 21:10
 55:4 59:6

I

I.D. 140:21
idea 36:9 53:10 62:19
 95:2 106:7 109:14
 129:14 130:4,5
 137:16 147:7 157:19
 159:8 176:4 177:5
 179:5 180:17 185:19
 190:3,16 193:15
ideal 136:19 139:4
ideally 39:8 104:22
ideas 100:22 108:6
 134:21 147:6 148:4
 148:10 157:14
identification 71:3
identified 23:8 29:21
 33:3 69:6 107:8
 122:17 140:4 172:7
 190:18
identifier 136:13 139:7
identifiers 143:2
identifies 43:4
identify 30:1 33:10
 43:18 63:4 73:17
 106:5 125:17 136:1
 139:13 171:14 172:6
 196:5
identifying 97:22 107:6
 172:1 174:18
ignorance 193:10
ignore 188:18
ignoring 193:11
ill 22:20 30:22 56:5
 57:12,12 107:2
 160:17
illness 56:6 57:1 129:1
 165:19 172:7 177:7
 177:11,15 180:13
illnesses 177:6
illustrate 49:19 85:10
immediately 56:3 68:9
impact 43:19
impacts 90:2 93:14
impart 190:10
impede 139:22
impedes 137:9
implement 66:3
implemented 193:20
implied 46:18,21 47:13
 127:3

implies 29:18 30:2
important 9:11,15
 10:13 11:12 12:15
 13:8 17:3 42:9 50:16
 54:14,18 57:16 63:8
 89:5 93:21 111:17
 120:8 139:2 142:22
 147:8 149:17 150:7
 156:7 167:16 175:1
 194:21 202:11 206:6
improve 59:15 85:4
 95:15 139:17 140:11
 150:15
Improvement 1:21 2:8
improvements 72:21
improving 197:9
in-between 122:3
in-home 175:18
in-person 105:5
inappropriately 201:4
incapacitated 142:17
incarceration 181:11
incentive 128:8
incentives 127:22
 178:16,17 198:13,14
incentivizing 179:13
 183:7
include 35:1 50:1 120:3
 153:10 202:20
including 74:10 190:3
inclusion 10:18
inclusive 137:18
income 152:10 175:11
incomes 174:8
incorporate 41:21 42:4
incorporated 190:19
incorrect 204:8
increase 173:10 174:16
 175:4,17
increased 174:14
increases 175:20
increasing 152:4
incredible 69:10
incredibly 111:16
indexed 129:2
indirect 194:13
individual 65:17 109:12
 138:20 173:17 196:11
individuals 39:11
 140:16
industry 42:18
inflection 86:15
infomatics 156:7
inform 118:18 122:18
 138:14
informant 187:9
information 7:9,17,18
 9:7,11,15,20 10:7

17:8 23:14 24:18 25:1
 25:5,7 27:7 28:7 29:7
 30:15 32:3,4,5,9
 34:14 35:11 38:16,16
 38:18,22,22 39:5,12
 44:1,5 47:6 49:18
 50:7,19 51:1,2,4
 59:14,14 71:8 75:5,18
 75:21 93:2,10,14
 94:13,14,15,16,18,18
 95:3,4,6,12,13 98:4,8
 107:7,17 110:13
 118:5 119:7 120:4
 124:8 127:15,15
 137:5,12,19 138:16
 139:2 140:20 146:20
 156:16 183:8 184:20
 185:1 187:12 190:11
 190:13 193:15,17
 194:6,7 195:1,1,11,14
 196:4 202:17 203:1
informational 35:9
informs 138:17
infrastructure 96:5
 118:8
inherent 192:19
initially 72:14 118:19
 124:4
initiated 111:11
initiatives 178:17
injuries 177:6
injury 129:1 177:12,15
inner- 49:10
inpatient 8:18 9:14
 11:11 65:11 93:9,17
 120:12 161:20 176:5
 176:13
input 70:7 133:20
 186:13 190:3
insofar 110:18
instances 33:11
instant 165:19,20,21
Institute 2:7
instruction 133:9,12
instructions 22:21 79:5
 203:12
insurance 173:2
insurer 173:9
insurers 173:4,14
integral 155:4
integrated 38:21 46:20
 48:3,11 170:13
Intelligence 2:14
intelligently 193:5
intensive 171:16
interaction 87:19
interactions 89:15,15
interdisciplinary 182:6

interest 147:4 197:8
interested 87:22 198:16
 206:4
interesting 50:17 58:13
 82:22 161:12 195:18
 196:13
interface 31:8
interfere 149:1,22
interfering 149:13
intermediate 59:2
 127:19
intern 163:19
internet 120:14 146:13
 146:15,19
internists 19:20
interoperability 28:7
 106:4 141:5 198:19
interrupt 160:11
intervene 132:8
interview 68:4 187:9
intravenous 116:6
intrigued 95:1
introduce 203:8
inundate 18:2
invasive 22:22
inventory 151:22
 164:16
invest 194:11,18,19
 195:9
Investigator 1:18
investing 199:18
investment 194:8,10
investments 170:7
involuntarily 31:1
involuntary 109:8
involve 175:7
involved 56:10 111:19
 159:9 160:14
involvement 85:3
iPad 157:1
isolated 37:11
isolation 43:13
issue 30:19 45:11 83:16
 87:17 88:21,22 107:5
 125:22 137:4 150:21
 177:10 180:11,12
 183:14
issues 6:5 80:13 86:8
 95:13 110:6 128:5
 136:1 137:3 143:7
 164:3 173:20 181:18
 192:22
item 79:19 80:9
items 28:6
iteration 83:13

J

jail 180:4,5

jails 180:16
JAMES 1:14
Janet 1:9,12 24:1 26:6
 39:15 135:2
jar 96:13
Jesse 2:20 4:4 6:10
 15:14 26:4 47:17 52:6
 63:1 83:6 103:15
 108:15 132:18 150:20
 160:13
Jesse's 13:22
Jessica 3:2 205:14
Jim 75:16 108:15
 115:11 131:22 136:19
 153:12 158:13 160:13
 162:6 164:13 176:4
 179:16 189:16 206:13
 206:14
job 96:13 158:18
 161:22 170:22
Joe 44:7 45:8 46:9
 123:9 158:11 160:12
 170:3 183:17 199:10
John 146:12
Johns 2:3
Johnson 2:15,15
join 6:17 167:22
joining 167:13
Joint 1:17
JOSEPH 1:19
Julie 1:20 28:7 83:7
 84:4 92:6 117:21
 123:8 125:4 139:5
 178:12 183:3 195:16
July 205:1
justification 50:13,15
justify 199:21

K

Kansas 44:14
KARAN 1:19 44:8
 123:10 158:12 159:16
 159:19 160:2,9
 183:18 199:11 200:22
 201:10,16
Karen 37:1
Karin 2:4 28:21 37:14
 51:13 59:20 91:3
 140:17 143:11 171:7
 178:5
Karin's 40:10
keep 29:13 45:13 46:8
 70:8 110:12 128:8
 143:3,4 157:19
 205:10
keeping 162:1
kept 32:3 119:8 122:20
key 7:8,17 10:7 16:9

32:3,4 34:14 49:18
 50:12,19 63:3 93:5
 111:15 119:9,12
 120:7 172:1 178:15
 187:9 193:17
Kidney 1:19
kinds 78:12 117:5
 124:14 126:7 135:19
 164:3 178:17 181:13
 182:11 192:14
kiosk 166:17
Kirsten 2:21 4:7 70:11
 77:13 135:2
knew 93:16
knowing 46:5 84:13
 127:6
knowledge 138:9
 181:20
known 70:13 155:8
knows 182:18 190:17
Kristin 117:19
Kyle 2:18 4:5 26:5
 31:21 49:12 70:3
 109:21 111:4,8 135:2
 201:22

L

lab 22:9
lack 65:15 66:2,10
 94:15 137:7 174:15
 176:10 177:11 179:6
 192:22 200:17
landed 32:1
language 37:20 40:11
 40:18 41:13,15,17,17
 41:18 42:4 78:19,19
 79:4,6 131:9,19
 186:13
large 22:12 99:18
 142:12 196:9
largely 94:12 194:9
lastly 150:20
Laughter 36:18 109:4
 201:13
law 31:4 74:10 109:7
laws 143:14
lawsuit 150:17
lead 20:19 31:21 44:18
 88:14 103:15 204:20
leader 155:15 203:11
leads 193:10
learn 17:15 64:8,15
learned 28:11 69:18
 202:18 205:3
learning 18:6,22 19:15
 19:17 69:17 106:6
leave 65:17,21 66:4
 68:10,11 85:16
 183:20
leaving 124:14 184:12
left 67:21 162:13
legislation 140:7
let's 8:1 27:5 31:19 46:3
 69:5 77:16 101:7
 128:1 134:13 163:21
 184:14 201:21
letting 192:9
level 21:12 48:10 53:4
 58:20,21 68:19 73:11
 95:5 96:17 103:1,6
 110:7 111:1 140:12
 173:18,19 176:12
 183:9 187:21
levels 126:3
leverage 75:3 120:2
license 99:21
life 22:21 199:19
lifetime 127:18
lift 135:8
light 101:2
lightbulb 186:18
liked 53:10 79:16
likelihood 132:15
limitations 18:1 95:19
limited 87:8 118:7
 138:4
line 93:15 181:22 199:4
lines 37:4 58:19 123:15
 133:19
linguistically 41:6
linkages 48:13,14
linked 172:10
linking 171:21
links 26:16
list 7:18 21:20 33:1
 43:12 73:19 93:11
 120:11,12,22 122:5,7
 123:19,20 187:21
listed 67:4 72:7 73:15
 150:3
listen 113:21
listened 135:15
listeners 133:20
lists 20:20 76:22 123:14
 158:20 174:6,7
listserve 204:10
literacy 37:20 113:5
literally 205:2
little 5:9 7:20 14:10
 15:5 23:9,12 30:19
 45:22 47:19 53:19
 70:4 71:16 77:15
 84:16 98:18 99:10
 101:12 103:11 104:10
 105:13 106:19,22
 107:1,3,21 108:5

123:12 135:8,8,10,22
 136:12,20,22 141:21
 152:16 161:7 169:2
 171:9 185:6,6 186:2
 186:18 187:3 188:13
 188:15,21 195:19
 197:13 200:21 202:6
live 100:17 190:11
living 123:14
local 45:11
locally 166:16
locks 142:19
logical 197:3
long 36:19 88:14 90:20
 123:15 157:2 174:7
 196:14 199:22
long-term 105:3
longitudinal 19:19
look 8:8 9:3 44:10
 45:15 54:16 61:12
 62:2 74:1 83:5 84:2
 85:3 101:11 107:11
 108:9,12 110:2
 118:15 120:5 121:13
 122:13 127:18 136:19
 150:10 178:20 179:22
 191:9,19 202:11
 206:11
looked 33:16 75:10
 113:19 121:1 122:12
 126:4 127:4
looking 5:15 23:6 41:3
 53:2 72:13,16,18
 81:10 85:1 102:3
 119:6 120:17 121:10
 125:15 147:4 153:15
 183:21
looks 73:1 150:15
loop 38:2 74:21 95:14
 108:20
lose 97:6 98:14 156:5
losing 51:14
loss 155:15
lost 28:11 29:8 70:14
lot 5:7 7:2 8:14 10:21
 11:3 12:8 15:22 16:17
 22:22 31:15 33:21
 37:4,13 42:3 47:21
 48:16 53:17 60:2
 61:19 63:15 64:19
 67:8 68:3 71:19 72:3
 75:4 80:13 82:10
 87:13 89:21 98:4
 99:21 100:22 104:16
 115:15 116:18 117:9
 117:9 118:5,21
 119:19 124:5 125:12
 126:6 128:16 129:1

132:5 134:19 139:14
 139:20 141:1 147:17
 148:1,2 151:1,10
 152:19 154:2 156:8
 159:16 164:13 177:12
 179:18 182:20 183:10
 185:10 186:2,9,10
 188:6 189:14 195:11
 200:3 201:1 204:1
Lots 186:14
love 101:3 159:8 204:11
 204:13
low 23:4 143:16,18
 175:11
low-income 184:18
lower 157:15
lowest 150:22
lucky 189:17
lumbar 145:6
lunch 4:14 103:13
 134:6,7,7,10,12
LVO 27:11 106:21

M

M.A 159:13
ma'am 199:5
magic 171:4
magically 186:12
main 196:15,17
maintain 121:3 162:15
 182:13
maintaining 73:19,19
major 88:21 90:2
 118:18 143:13
majority 61:15 87:3
 180:1 197:22
maker 148:13
making 11:15 34:5
 35:12 45:3 51:1 52:13
 54:13 65:4,8 69:8
 72:4 74:15 107:7
 112:22 113:3,8,18
 114:21 117:10 118:20
 119:16,18 136:7
 141:22 144:2 169:1
Malta 2:4
mammogram 145:5
 147:20
managed 180:3
management 2:5,5
 65:22 72:21 117:4,4
 120:18 121:7 171:21
 177:10 179:19 191:21
 193:22
manager 2:21 159:17
 159:21
managers 155:13 156:4
 166:9,11,14 192:6

managing 180:13
manner 71:9
Marc 2:3 37:2 54:13
 66:20 88:1 90:7 105:8
 146:2,7
Marcia 2:21 4:8 13:18
 45:6 94:6 125:10
 131:21 135:2 197:11
 204:3
MARGARET 2:14
MARGOLIS 3:1
Marine 99:18,19,22
marker 57:21
Marsha 17:19 34:11
 52:6,19 74:13 77:15
Marvelous 77:13
Maryland 194:16
masse 184:10
MASSEY 1:20 28:9 84:5
 92:7 117:20,22 124:3
 139:6 178:13 183:4
 195:17
match 157:16 163:2
matching 193:3
materials 79:5
matter 102:16 146:14
 154:11 155:5 188:8
 188:10
matters 167:11
maximize 40:22
Mayo 2:17
MBA 1:16,20 2:10,21
MD 1:11,13,14,17,20
 2:1,2,4,8,10,20 4:2
Meals 124:12 138:3
 169:16,17,19
mean 25:16 27:22
 36:10,12 67:14 76:20
 77:3 86:16 143:7
 144:5 157:19 159:1
 160:10 163:4,17
 164:7,11 180:9
 184:21 189:13 190:14
meaning 149:20 150:14
meaningful 50:22 78:11
 153:7 180:22 183:7
 201:5
means 25:21 67:14
 138:13 139:9 143:16
 144:20,21 164:14
 202:16
meant 90:13 100:4
measurable 112:21
 161:6
measure 4:10 7:5 10:6
 10:13,22 11:2,5 12:7
 14:15 15:13 16:9 20:1
 23:15 32:15,16 40:17

42:14 43:2,5 45:19
 50:13,16 52:18,21
 53:9 54:19 55:1,21
 56:17 58:9,12,14,21
 58:21 59:4,8 66:8,12
 66:14,15,17,19 67:17
 68:22 71:6 73:6 74:5
 76:13 79:12,18 80:9
 81:2,3,22 82:2 84:13
 85:6 94:8 100:12
 101:18,20 105:16
 106:1,17 107:11,13
 107:13 108:8,20
 109:9 119:10 120:6
 120:17 126:13,15,15
 128:17 129:10,11,14
 130:11 148:20 160:16
 161:5 179:9 202:21
measured 25:21 31:12
 46:5 112:10 160:15
 161:5
measurement 1:17
 2:18,20,22 4:16 24:15
 34:6 57:18 128:15
 178:21 197:20 198:6
 198:8
measures 6:20,21 7:3
 8:14,18,21 9:3 10:2
 10:15,19 12:9 14:20
 15:13,16 21:19,21
 22:6,8 24:8,22 25:3,4
 26:8,11,21 37:4 40:15
 40:19 41:5 42:3,10,19
 45:17 49:16,17 50:9
 51:1 52:1,5,22 53:1,7
 54:9 57:19 59:12
 70:18,19 71:11 72:6
 75:11 76:18 78:12
 79:13 80:17 81:6
 83:10,13 84:16 87:9
 87:11 88:8 103:4
 106:14,19,20 113:18
 114:15 120:5 121:1
 125:18 128:16 135:10
 147:18 148:1 149:12
 149:16,17 151:2,9
 152:1,6,9 164:19
 202:21 203:7,17
measuring 14:21 21:6
 21:12 31:3 84:8
 108:22
mechanism 90:4
med 81:5 82:9,12,16,20
 84:8 92:3 93:14 98:18
med-rec 33:1
Medicaid 175:11
medical 1:11,15,20 2:8
 2:9 10:9 11:5,20

16:15 99:2 126:8
 146:13,15 151:1
 153:16 157:5,12
 167:6 180:15 187:1
 192:22 200:9,15
Medicare 58:1,4 63:10
 64:11,18 140:5
medication 11:4,7,16
 11:17 13:17 14:2 65:5
 81:7,11,15,19,20,21
 82:1,4,15,16 83:9,14
 83:20 84:19 85:5,22
 86:12,20 87:7,18 88:5
 89:8 92:12,14 93:22
 94:2,4,5 98:19 103:20
 104:7 125:15,21
 159:6 163:5 184:19
 185:9,14 188:8,9
medications 32:20,21
 38:6 85:17 87:14 88:4
 89:1,4 91:6,12,16
 99:5 187:19 188:7
medicine 1:12,13,15
 2:4,6,9,11,12,13
 23:18 67:7 115:20
 116:17 157:10,15
 167:10,15 168:2,2,19
 169:4 189:22 190:18
medicine's 86:7
medicines 114:1
 163:20
meds 84:21
meet 10:17 203:14
meeting 68:7 126:22
 135:4
meetings 170:18
mental 33:12 52:15
 180:13
mentally 30:22
mention 55:15 178:15
mentioned 34:11 63:5
 67:8 80:14 118:2,14
 138:5 139:6 144:19
 150:20 158:14 169:12
 170:4 172:13 178:19
mentioning 176:19
message 173:13
met 1:7 174:19
methodology 63:6
metric 13:1
metrics 83:18 84:3
 118:16 206:22
MHS 1:17 2:10
Miami 44:12
mic 64:12
Microphone 37:16
mics 37:18
middle 56:11,18 172:3

migraine 164:4
mike 118:3
million 189:20
millions 192:15
mind 88:17 128:9 150:8
 157:19 205:11
mind- 193:9
minds 73:14
mindset 179:4
mine 145:8
minor 57:15
minors 33:12
minutes 9:9 103:12
miscommunication
 61:2 65:15
missed 49:4 75:8
 128:11
missing 93:2
mistake 164:17,18,21
misunderstanding
 144:7,16
mobility 72:21
MOBLEY 1:21 62:1
 76:12 77:7 85:9
 141:19 144:13,17
 162:5 186:7
modalities 33:17
 110:17
modality 7:21 32:3
 33:15 34:15 38:19
 50:18,19,20 51:7
 128:7
model 129:15,22
 153:22 160:20 168:17
 168:22 169:2 172:13
 172:14 178:1
models 157:7 167:14
 173:1
modified 8:20
mold 182:18
money 101:19 153:5
 154:17 158:5 170:3
 176:5 186:9,10 197:5
 200:2
monitoring 90:5
month 151:12 172:4
 202:14,14,15 204:7,9
months 77:10 147:21
morning 5:3 13:21
 30:18 31:22 47:10
 70:6 83:1,5 97:3
 102:6 103:21 112:15
 135:13 136:13 154:14
morning's 103:1
morphed 51:15
motto 99:22 100:3
move 14:1 24:11 31:19
 70:9 79:13 81:2 102:7

125:8 127:19 174:5
 178:1 183:9,12 202:1
moved 96:7
moves 29:22 181:10
moving 107:8 109:20
 115:20 127:4 155:2
 175:9
MOY 2:19
MPA 2:7
MPH 2:8,19,19
MRI 154:13
MSN 2:14
multiple 50:11 52:15
 54:11 65:9 66:9,15
 77:5 86:13 100:17
 130:9 188:7
MUNTHALI 2:19
mutually 105:20

N

N.W 1:8
name 145:21 173:8
 201:17
named 190:1
names 182:2
narcotics 163:14
national 1:1,7,19 44:10
 45:11 126:20 136:13
nature 147:2 150:18
navigator 120:18 121:7
Navy 155:22
NEA-BC 2:16
near 168:14
near-term 197:19
necessarily 13:4 22:21
 56:2 57:21 63:18
 69:21 87:15 93:20
 104:14 147:19 149:16
 159:11 171:1,3
necessary 6:6 20:15
 195:4
need 20:6 28:17 32:15
 33:9 41:15,16 43:8,14
 43:16 44:2 45:12 46:1
 46:2 56:2,7 57:4
 59:12 61:7 62:5,11,12
 63:17 64:1 65:20 66:3
 74:6 98:8 105:8
 114:17 119:12 121:17
 122:22 125:17 127:14
 132:11 135:11 136:1
 136:5,7 140:13 142:9
 149:18,21 151:8
 152:17 153:8 154:2
 154:21 157:18 166:13
 169:13 170:19,20
 172:11 174:5 176:20
 176:21,22 177:3,7

178:4 179:8,10
 182:17 183:10 184:2
 184:5 194:7 195:2
 198:19 200:9 206:22
need-related 122:21
needed 48:14 116:2
 196:6
needle 21:5 206:9
needs 17:18,22 19:11
 33:19 34:1,22 46:4
 50:18 52:3 53:20
 57:12,13 58:17 62:7
 78:21 94:3 97:12
 107:22 112:10 118:16
 122:6,16,18 123:4,6
 123:11 124:9,15
 128:7 136:3 139:9
 145:10 152:5 154:18
 157:2 166:4 169:16
 171:19 174:19 182:10
 183:8 195:11
neighborhood 114:12
network 66:2
never 77:1 85:19 86:2
 127:6,8,9 132:17
 158:1,2 185:8 194:20
 195:8
new 22:15 40:14 85:21
 90:17,18 91:11
 107:12 108:17 151:21
 156:14 157:22 167:14
 172:6 184:6 194:8,9
next-to-last 203:20
nice 6:16,18 130:22
 134:10
Nicki 1:17 54:4 55:12
 63:8 89:6 90:9
night 6:17 146:12
 151:19
Niles 1:9,12,13 24:2,7
 24:10 37:16 39:16
 64:12 134:13 135:6
 139:1,18 141:18
 142:6 143:11 145:19
 146:2,6 152:12
 153:12 158:10 159:10
 159:18 160:1,8 162:3
 171:7 172:17 173:21
 176:1 178:12 179:15
 182:19 183:17 185:5
 187:6,15 189:16
 195:16 196:20 197:10
 199:3,10 201:18,21
 205:14 206:14 207:2
nine 190:18
nodding 115:2 119:19
non 151:9
non- 198:20

non-face-to-face
 152:10
non-fee-for-service
 168:15
nonprofit 182:14
noon 103:14
normal 132:17
normally 80:21
north 99:18
Northwell 2:6,6
note 51:12 81:22
 152:17
notes 53:2
noticed 81:5 206:20
notif 196:5
notification 10:8 12:15
 23:21 107:14 189:6,7
 196:17
notified 196:6
notifiers 196:16
notion 153:20
NQF 2:17 4:13,17 9:1
 83:9 106:3 131:7,19
 135:3 148:21 204:6
 206:16
NRP 3:1
NSID 91:22
nuances 186:2
number 16:3 21:19 24:3
 60:18 69:22 73:7,15
 76:13 80:16 89:13
 100:7 122:19,20
 126:9 127:7 129:17
 130:6,19 134:1
 162:21 185:9 193:1
 199:7 200:10
numerous 184:17
Nurse 2:16
nurses 117:7 184:3
 185:18
nursing 17:11 86:4 95:8
 95:10,16 120:20
 158:19
nutrition 175:17

O

obesity 62:14
obs 171:16
obser 116:15
observable 20:8 63:9
observation 116:16
 129:20 166:18
observed 179:18
obstacle 197:19
obstetrics 116:17
obstruction 22:13
obtain 89:4
obviously 17:8 20:6

21:1 24:19 78:21
94:18 137:20
occur 96:15
occurring 73:3 129:6
Oceanside 99:19
odd 19:1
offer 164:1
Office 2:5
officer 109:8
officers 31:17
officially 191:10 192:13
offload 117:8
oftentimes 137:12
157:20
OIDTMAN 3:2
OKER 2:1 61:11 116:22
old 55:4 90:17 163:20
166:21
older 58:7 160:16
175:14,15,15
OLDTMAN 205:16,19
ONC 190:6
once 30:1 48:10 61:15
145:6
oncology 155:11
one's 152:4
ones 19:17 27:9 30:21
73:9 85:15 90:6 121:8
131:17 157:21 196:7
online 157:12
open 133:19 136:16
199:4
operate 116:8
operating 181:6
operation 42:14
operationalized 141:1
Operator 133:18,21
134:5 199:3,5
opiates 87:13
opportunities 154:6
opportunity 29:6 64:8
64:14
opt 140:21,21 141:7,11
142:10,13,14 143:6
143:14,18 144:9,10
144:19 145:15
optimize 17:19 164:22
183:11
optimized 49:6
opting 143:19 145:8
order 40:21 41:9 90:3
132:12 136:2,8
154:22 175:6 195:5
Oregon 191:7
organizational 95:5
organizations 75:19
78:18 137:6,15
151:11

original 73:1
originally 79:12
osteoarthritis 55:4
ought 38:7 60:22
outcome 47:10 59:4,15
59:16 69:4 80:4 82:12
82:14 83:4,13 96:19
98:9 108:19 126:15
128:17,19 129:6
132:20
outcomes 2:13 4:9
14:17 15:11 17:21
28:5 29:22 46:11
48:20,21 49:5 54:17
59:2 79:7 84:16,17
96:7,14 97:1,4,15
98:14 99:4 120:6
122:13 125:9 126:4,7
127:19 128:15 140:11
150:15
outpatient 54:21 55:5
89:18 93:7 164:16
outside 10:3 28:18
151:16 170:21
ovarian 163:15
overarching 136:1
overcoming 137:17
overlap 71:19
overlapping 10:22 72:2
overload 59:6
overlying 37:13
overnight 169:8
overriding 146:22
owner 2:3 141:22
owning 143:21 147:12
147:13
owns 14:11,12 144:6,7
144:21 147:9

P

P-R-O-C-E-E-D-I-N-G-S
5:1
p.m 134:12 207:7
packages 167:14
packet 187:13
paid 68:13,16 150:22
151:16 168:3 194:14
pain 16:5 72:21 163:12
163:20 165:7 177:3
pain-seeking 191:13
paired 66:18 81:22 82:5
126:13
palliative 65:12
panel 1:3,7 4:3,15 5:14
32:18 69:11 100:6
134:11 205:8 206:2
207:7
panel's 202:20

panels 5:11
paper 67:12 154:3
162:6
parallel 39:3 40:9 116:2
paramedicine 157:8
paramedics 138:1
157:1
parameters 101:21
parsimonious 101:6
parsing 14:9
part 28:5,15 29:3 33:1
34:4 39:7,8 47:22
50:16 54:14 67:3
68:17 77:3,21 78:9
111:1,11 118:4 124:8
124:17,21,21 155:4
181:16
participation 143:17
particular 20:16 75:21
82:11 84:19 136:14
205:22
particularly 16:11
18:15 20:4 21:15
64:18 84:8 87:12
198:16
partnered 31:17
partnering 173:9
partnership 181:6
pass 109:3,22
path 202:6
pathway 16:12
patient's 34:22 35:1,7
35:15 41:13 60:3 72:9
72:20 77:4 79:21
80:12 112:3,16
114:18 166:3 183:19
184:12 192:13 199:13
patient- 149:10
patient-centered
165:18 167:1 177:18
patient-centric 111:12
patient-friendly 141:21
patient-related 149:9
patient/provider 71:22
patiently 152:15 162:4
pattern 61:14
paves 93:6
pay 140:9 152:4 173:12
payer 117:3,6 118:4,9
123:18,22 175:10
payer's 185:21
payers 74:11 75:3
121:9 136:8 152:18
152:22 153:2,2,11
155:18 165:4 168:1
196:3,4,9,15 197:2,3
paying 168:1,13,14
196:7 205:18

payment 121:10 155:1
158:5 167:9,13,14
168:5,7,17,22 169:3
172:11,20 173:6
178:18
payments 105:10
167:10 171:13 194:15
PCP 11:6,6 76:22 77:9
78:3,3 107:14
PDMP 195:13
PEARSON 2:2 142:7
144:5,15 145:13
187:16 196:21
pediatric 2:2 182:17
pediatricians 19:20
pediatrics 33:11
pending 85:16
penetration 167:20
Pennsylvania 31:2
people 13:13,14 18:18
21:7 31:16 44:12
45:13 49:2 54:11 58:5
59:9 60:7 67:8 74:11
86:18 90:11 97:18
105:3 115:13,14
117:3 130:19 142:12
143:1,10,14,15,19
154:16 155:6 157:18
162:21 163:10 167:11
168:9 171:21 172:8
172:14 174:8 175:19
176:19 180:2,20
181:10,16,19 182:3
185:7,10 193:19
200:3 202:9 204:12
206:3
people's 28:3 34:17
174:19
percent 23:1 115:13
133:5,6 149:8,9
162:10 193:9 206:19
percentage 22:8,12,19
23:6 24:3 27:10 121:5
perception 79:22
perfect 184:1
Performance 4:16
period 9:8 12:18 13:14
13:16 25:19 91:15
170:12
periodic 182:10
periods 12:21
peripheral 194:12
permanently 190:10
permission 198:9,10
person 13:6 62:21
63:15 132:8 136:13
144:3,6,7 147:9 160:3
185:8

personal 140:21 197:18	154:10,13,17 157:7	194:15	5:15
Personally 142:13	178:21 199:18	populations 16:3 98:3	presents 114:13
perspective 14:8,15,19	placed 72:6	122:1,10	preset 188:16
14:22 112:3 113:2	places 166:10	portals 51:5	President 1:12 2:4,19
147:18 194:1	plan 38:3 44:8 50:4,4,6	positive 19:3	2:21
perspectives 204:15	53:8,11 58:20 60:4,7	possibilities 159:5	presiding 1:9
Persse 157:5	60:12,13,17,18 66:3	possibility 108:22	press 134:1 199:7
pharmaceutical 184:18	66:16 72:11,19 102:4	115:17 132:3	pressure 21:11 62:14
pharmacist 185:19	105:18 119:11,12	possible 14:19 15:13	156:9
pharmacy 85:2	191:11,16,22 193:16	31:7 41:9 70:10 76:13	pretty 29:13 41:11 87:8
PhD 1:21 2:16,21 3:1	planned 66:13	possibly 44:9 172:15	143:5 161:10 169:22
Philadelphia 195:18	planning 117:9	post 22:20	193:9 202:9
philosophical 126:18	plans 15:18 16:2 138:8	post-acute 11:9	prevent 59:22 61:8
phone 60:18 61:5 105:6	138:11 140:6	post-comment 205:2	132:9
133:19 165:10	plates 99:21	post-ED 12:12	previous 73:22 76:4
phrase 148:8 149:4	play 44:3 50:19 109:17	post-operative 53:8	84:19 170:11
physician 1:17 2:3	132:13 146:16	post-OR 75:11	previously 73:8 122:16
10:10 16:16 17:6 18:3	please 51:9 52:17 71:10	potential 16:9 21:21	PRICE 2:3 37:3 66:21
27:8 44:19 91:11	82:6 103:16 111:2	81:1 105:22 123:5	90:8 146:1,4,8
94:19 105:1 107:18	134:1 199:7 200:22	130:11 150:17 188:12	primarily 15:17 92:9
120:20 149:7 158:19	205:12	potentially 7:1 8:19	105:1
162:8 173:8,9,14,18	plug 146:16,16	10:1,17 63:9 85:2	primary 2:8,16 10:9,10
185:17 189:12,12	plugged 90:3	104:9 106:20 124:10	11:5,20 12:10 16:15
191:22	PM 10:9	129:22	16:15 17:6 27:7 43:17
physicians 11:15 12:11	PMD 11:22 12:18 23:20	practice 54:15 62:16	56:7 62:16,21 67:7
19:19,20,21 40:13	105:21	practices 45:10,17	72:9 76:15 91:14 92:4
44:22 71:18 132:22	point 13:20 14:6,13	54:20,21 55:8	93:8 104:22,22
133:3 156:19 167:17	45:8 54:7,13 66:19	pre- 21:22 106:15	107:18 119:22 132:22
179:10 184:3	68:18 78:15,21 81:8	pre-gathering 185:1	133:3,10 147:18
PI 189:21	81:16 82:8,19 86:9,15	pre-hospital 22:3,9	148:2 150:22 151:4
pick 134:7 136:19	90:8 100:2 116:22	26:13 30:20	152:8 162:10 165:9
189:10 196:14	128:1 142:8 144:7	Pre-tech 42:21	168:20,22 171:22
picked 203:1	145:2 150:4 184:15	precautions 89:20	173:11 175:10 177:14
picking 125:17	187:17 194:22 195:10	predict 132:4	178:20 179:11 189:4
picture 45:16 87:8	196:4 202:9 206:17	predicted 129:22	189:6 191:22 198:3
122:14	pointed 64:22	predictive 132:15	printout 8:5
pie 147:6	pointing 150:10	predictor 58:17	prior 23:8 37:5 98:18
piece 14:11,12 24:12	points 86:13 150:1	preferences 32:20 35:1	140:19
29:13 93:2 121:4,12	police 28:13 30:21 31:7	80:5 113:6	prioritization 202:21
121:13	31:17 179:21 180:4	preferred 41:18 78:18	203:21
pieces 38:18 103:22	180:11 181:7	preoperative 151:6	prioritize 182:12 203:17
pigeonhole 157:20	policies 148:12	preoperatively 73:2	privacy 137:4,16 139:9
pills 85:20	policy 3:2,2,3 124:2	prepared 119:4 163:8	139:20 141:6 142:22
pilot 138:1	140:3,12,13 148:13	prescribe 113:9 187:18	192:22
pilots 64:16,21 69:17	171:8 172:19 175:2,7	188:8	private 61:12 136:8
PINE 18:8	175:8 176:12 182:21	prescribed 88:13,22	143:3,4 167:22 173:2
Pines 2:20 4:4 6:15	193:22 198:13	89:19 90:12 91:12,16	probabilistic 193:2
15:15 18:13 24:6,9,13	policy-level 136:6	94:2	probably 23:12 24:10
26:20 27:3,21 30:3	polypharmacy 65:3	prescribing 86:21	31:15 84:2 87:18 99:5
47:18 63:2 83:8	172:4	87:11,17,19 88:4 89:9	112:9 128:3 134:18
103:17 132:19 160:13	poor 82:16 129:7	104:7	161:22 190:17 191:17
172:21	130:11 154:8 170:9	prescription 189:5,9	192:16
pings 188:16,17	171:14	prescriptions 85:21	problem 41:22 67:11
pitch 182:5 204:4	population 2:5 15:18	87:3 90:1 187:17	85:10 86:1,1,7,13
pla 60:11	58:1 61:12,17 101:13	present 1:10 3:1,4	87:16 89:16 122:5
place 41:2 84:2 87:10	121:18 130:8 133:8	205:3	144:2 149:19 154:15
92:19 108:11 116:18	148:17 175:21,21	presentation 56:6 57:2	163:18 171:5 177:9
120:10 121:2 136:11	population-based	presentations 4:3 5:10	177:14 184:8 193:6

problems 77:5 83:21
89:8 123:17 136:11
172:16 200:16
process 34:4 82:13,20
85:6 88:16 96:16
108:8,10 109:9 120:6
120:10 121:2 122:11
126:15 150:11 164:3
204:6
processes 59:7,8,9
processing 116:2
product 198:1
productive 134:22
206:17
products 41:12 78:1
Professor 1:13,14 2:4
2:11
profitable 134:21
program 44:10 85:12
138:1 181:4 191:6
programs 15:22 16:10
64:15,21 69:18
123:18 160:20,21
173:16 182:12 183:21
184:18
progress 103:7 150:10
project 2:19,21 73:5
98:5 106:10
promise 170:8 186:11
proper 89:20
properties 7:9,17,21
10:7 38:17
proportion 54:22
propose 56:16
proposed 120:17
proscribed 13:5
protecting 150:16
provide 32:15 108:18
122:9 174:16 195:5
provided 32:10 35:9,11
provider 4:4 6:10,19
14:14 15:7 16:20,21
19:11,13 28:2 29:1,2
29:3,14 38:12 71:20
72:7,10,15 76:15 77:9
79:3,13 88:3 89:10,18
91:15 92:4 93:8 94:9
94:16,21 95:2,11
108:12,19 110:13
111:20 113:20,21
119:22 124:21 141:3
165:10 166:21,22,22
171:22 189:7 196:18
provider's 94:11 113:2
provider-patient/carer
111:13
provider/patient 42:7,9
providers 17:15 19:19

28:12 30:20 31:14
38:15 39:6,13 43:17
138:2,5 141:15
152:19 153:1,3 165:4
168:7 174:9 192:8
193:19 196:11
providing 61:3 119:6
153:5
provision 153:3
provocative 171:2
psych 109:8
psychiatric 31:16
public 4:13,17 181:9
195:4 199:8 204:5,7
204:13,16
publication 160:14
pull 60:19 64:12 79:20
80:11 156:16 176:16
186:15
pulled 195:12,14
pulling 84:1 105:2
200:18
purchased 201:2
purple 202:8
purpose 56:20 57:1
purposes 18:14 80:19
106:6 121:10
pursue 126:10
purview 20:15 100:14
106:2
push 48:9 156:16
170:21 183:6 205:11
pushed 170:15 195:11
201:5
pushing 15:6 82:18
206:8
put 12:20 27:6 44:9
86:6 107:16 115:7
128:14 130:21,21
131:6 137:15 145:8
151:15 166:7,10,15
171:15 173:16 178:21
178:22 180:4 200:20
204:5,6
puts 130:5
putting 35:19 98:11
117:13

Q

QA 108:8,10
qualified 40:14 107:11
qualify 132:12
qualitative 34:3
quality 1:1,3,7,16,21
2:8,9,11,15,18,19,22
23:15 38:22 40:15,22
42:14 45:19 46:3 48:7
57:18 66:15 84:8 85:4

86:16,20 87:16,20
88:2,5 91:8 94:15
95:12 106:1 108:1
126:21 188:12 197:20
198:6,7 206:22
question 39:17 45:3
57:5 77:8,20,22 78:4
78:8 93:20 94:3 96:15
96:19 162:5 185:13
questions 5:18,19 26:4
28:21 30:5,9,11 35:5
79:21 80:3,7 98:15
108:14 113:20,20
115:10 117:15 123:9
125:5 133:16,20
136:5
quick 70:22 76:2 112:4
quickly 14:2 42:14
111:21 116:20 156:21
183:12
quite 5:4 6:7 83:2
116:10 134:21 188:10

R

radio 157:11
range 44:22
rank 203:7
rant 152:11
rapid 172:9
rate 59:10 196:12
rates 143:16,19
re- 156:9
re-looked 154:19
re-say 200:7
re-thinking 153:20
reach 28:17 158:16,20
reactionary 179:14
read 8:6 38:1 85:14
readmissions 64:17,22
69:17
ready 99:6 103:13
201:6
real 76:19 101:16
156:21
realigned 161:21
realistic 101:7 148:22
realize 124:20
realized 96:22
rear 150:16
reason 37:12 54:17
56:21 60:2 62:6,20
63:7 68:14 81:21
130:3 167:11
reasonable 61:6 102:9
reasons 16:5 178:19
reassigned 161:20
rec 82:9,12,16,20 84:8
93:14 96:12 98:19

recap 4:2 32:1 33:4
recategorize 110:5
receive 12:19 13:8
19:21 119:4 152:22
183:19 203:10
received 19:8 49:22
50:3 69:10 95:4
175:20
receivers 196:15
receives 94:16
receiving 9:12,19
104:11
recessed 134:12
recognition 31:13
174:22
recognize 118:21
120:12 121:16 124:9
124:19 167:17 171:2
recognized 121:20,22
recognizing 179:2
198:20
recommend 7:4 35:14
recommendation 41:4
96:9 119:14 126:14
139:15
recommendations 4:15
42:8 48:2 83:12 128:4
128:9 136:6 140:4
171:9 182:21 202:20
203:17
recommended 63:19
96:12,17 122:9
reconcile 85:15 190:8
reconciled 85:14 91:5
reconciliation 11:4,7
11:17 13:18 14:3 81:6
81:7,11,15,21 82:2,4
83:9,14,20 84:20 85:5
85:22 86:12,21 87:7
88:21 89:8 91:11,13
92:3,13,22 93:7
103:20 104:7 125:15
125:22
reconnect 124:13
reconsider 25:14
reconvene 102:9,20
reconvened 134:12
record 9:10 29:10 49:21
60:19 85:12 86:5
102:17 113:11 189:8
190:10,20 193:1
198:5
recorded 112:11
records 22:3 141:2,3,15
141:16 143:22 144:3
144:6,8,9,12 146:10
187:4 190:8
recreate 44:5

recreating 45:14
red 21:17 188:21
redefine 166:19
redefines 166:6
redefining 7:7 164:14
 164:15 171:11
redesigned 169:6
reduce 40:21 59:10
 64:17 69:14 131:13
 140:10
reduced 64:22
redundancies 99:3
 152:20
Reed 2:21 4:7 70:12
 76:17
refer 11:21
referral 17:5 24:1 74:1
 74:21 119:15,17
referrals 17:19 74:22
 118:21 176:8,9
referred 65:12
refills 163:5
reflecting 112:22
reflects 31:12
reform 158:6 172:20
refrigerator 85:18
refused 110:1
regard 34:21
regarding 53:11 64:10
 147:10 153:9
regardless 48:4 123:13
regards 37:19
Region 2:15
regionally 44:11
registration 41:11 78:9
registry 40:14,19 198:5
 198:6
regular 73:18 88:11
 148:3
regularly 73:19
regulation 139:22
 151:21
regulations 139:19,21
 140:6 152:1 153:8
regulatory 140:14
 167:8 195:3
reimbursement 127:22
 128:5 151:9
reimbursement's
 150:21
reinforce 120:1
reinvestment 168:8
reiterate 178:15
related 15:16 20:10
 26:21 40:9 76:4 82:16
 83:14 89:7 90:6 97:9
 98:19 99:1 148:19
 149:11 169:9

relation 87:19
relatively 90:2
release 31:7 92:10
 184:5
relevant 6:22 7:4 8:15
 8:22 12:13 71:7 79:21
relieved 35:8
rely 119:15 175:19
relying 124:6 125:1
remainder 135:3
remarks 51:13
remember 151:15
reminder 70:22 189:10
 189:12
reminders 188:16
renal 92:1
repeat 52:6 76:5,10
repeatedly 76:8 112:13
 180:14
replace 90:13
report 4:12 6:4 15:5
 40:15 102:11 202:13
 202:19 203:18 204:5
 204:7,11,21 205:12
 206:11
report-backs 102:21
report-outs 135:15
reported 41:13 97:15
reporting 41:1 42:13
reports 64:20
repository 142:1
 144:18 145:17 157:14
repurpose 80:11 81:11
repurposed 71:13 73:5
requested 21:14
require 129:2,18,19
required 105:9 152:8
requires 58:8 163:12
 165:19
rescue 28:13
Research 2:11,13
reshifted 119:5
resonates 130:14
resource 27:13 117:1
 117:11 118:12 120:11
 120:22 122:7,22
 155:12 156:10 174:15
resources 28:18 48:19
 114:11,12 116:14
 118:9,15 121:7,11
 123:12 157:17 158:17
 158:21 159:4 161:19
 163:1 166:7,16 168:8
 169:14,15 170:20
 171:4 175:6 178:20
 179:1,3
respect 86:20 181:22
respected 80:6

respectful 114:20
respond 143:12 204:18
 205:9
responded 205:4
response 45:7 109:19
 117:17 125:7 133:17
 201:20 204:19 205:7
responsibility 31:6
 65:22 77:4 91:14 92:5
 109:13
responsible 65:21
 74:15 150:8 196:18
rest 5:14 32:18 183:15
result 34:16,16 82:15
 84:18 138:8
results 19:22 88:5
 138:11 165:15
resumed 102:18
retire 174:5
retrievable 79:1
return 60:3 127:5 131:2
revenue 174:10 175:17
reviewing 73:1
revisit 47:11 123:3
revisiting 51:22
revisits 84:18 122:14
 122:15
revolve 111:10
revolved 110:8
RHODES 2:4 28:22
 37:19 59:21 91:4
 140:18 143:13 171:8
rid 38:19
rise 162:20,21,21,22,22
 163:1
risk 10:15 13:14,16
 15:18 16:3 20:4,5
 21:16 23:19 25:20
 34:7,10,16 36:9,15
 43:12 49:7 51:11
 52:16 54:1,14,16
 55:19 56:19 57:3,5,7
 57:21,22 58:2,16 61:5
 62:2 63:4 64:2,10,17
 65:1 69:15 87:13
 91:16 104:21 106:9
 106:11 121:14 167:22
 170:9 171:14 173:15
 188:17 189:1
risk-adjusted 129:15
risks 43:20
RN 1:12,21 2:14,16
robust 15:13 17:21
role 43:22 106:14
 112:21 119:20 132:14
 139:12 156:12 171:11
 182:22 183:1,2
room 1:8 138:22 148:16

157:4 159:9 162:7,10
 183:20 184:2,4,12,16
 185:3 186:21 192:13
 200:2
rooms 169:11
route 192:8
routine 29:18 30:2
routinely 29:21
Rowan 1:22
run 6:2 170:3
running 99:9
rural 48:4 49:9
RX 51:20

S

safe 87:11,17
safety 2:11 30:10 79:10
 79:13 80:15 83:11
 87:8 96:6
SAFR 190:8
salience 7:22 35:10
Sam 2:14 41:2 66:6
San 1:15,15 99:17,18
 100:2 137:22 138:6
 181:5 189:18
satisfaction 68:20
Saturday 155:5
save 55:12,14 66:21
 158:5
saw 32:4 99:21
saying 40:5 55:13
 86:13 90:9 132:14
 160:13 176:4 182:16
 184:3,4 185:7 186:4
 192:21 204:1
says 67:13 154:3 194:7
scan 163:11 165:13
 177:20
scanning 42:21
scarce 174:10
scared 200:12
scary 199:19,20
scenarios 86:19 106:12
 109:11
schedule 5:5 70:5
 77:14 165:11,13
SCHMITTHENNER 2:7
 34:21 35:13,17 64:7
 64:13 88:20 93:19
 140:2 174:3
school 1:12 2:6,10,13
 158:22 163:20
Scientist 2:12
scope 106:20 107:19
 109:6
score 203:7
screen 86:6 122:11
 188:22

screening 29:18 30:2
122:11 132:12
se 161:4
seal 142:18
second 41:15,17 58:10
59:22 61:8 72:22
96:14 100:20 112:12
120:16 121:4,12
132:16
sector 169:13
seeing 68:15 98:2
119:7 146:20
seen 68:12 77:1,9 89:9
169:16 189:4
sees 11:6 19:13
segment 61:17
segments 195:7
selection 89:11
selective 138:17
self-management
175:18
sell 144:22 151:19,20
semper 99:22 100:3,4,5
send 67:18 68:9 100:8
163:14 172:8 190:7
sending 17:7,8,10
68:18
senior 2:7,18,21 138:2
sense 39:2 45:3 77:21
91:10 100:13 130:15
166:2,8
sensitive 35:12 81:12
131:19 132:2 177:6
sent 9:7 16:21 19:4,5
sentinel 132:4 172:5
separate 198:22
series 35:4 50:9,22
52:5
serious 172:6
Seriously 81:8
server-based 147:14
serves 156:12
service 2:2 42:17 43:4
64:10,18 68:3 178:3
services 65:13 71:5
73:18 97:10 117:5,5
119:3,17 120:2,18,22
123:16 124:1 125:3
140:8,10 153:6
157:22 170:1,2,10,13
170:20 174:13,16
175:7,12,14,15,19
176:10
sessions 100:9 101:1
102:5,8
set 41:11 78:20 101:6
129:15 138:4 157:6
164:17,21 200:14

setting 18:1 65:18 66:4
81:7 87:4 94:21 96:3
96:4,14 98:6 114:13
120:21 127:16 129:12
129:20 165:22 168:11
settings 16:22 17:2,5
17:10 18:15 19:10
95:20 118:6
seven 9:2 90:19
share 71:9 75:18,20
91:4 137:8,18 138:1,2
138:3 143:21 144:3
145:1 191:16 199:1
204:11 205:5,12
shared 7:12 8:3 11:19
12:2 34:5 35:12 46:12
47:7 69:7 74:14 91:14
97:2 100:17 112:21
113:3,8,18 114:21
126:17 127:2 146:11
167:22 196:8
sharing 59:15 92:8
137:4 138:13 153:9
shift 118:18 179:3
shifted 175:4 179:20
shifting 180:6
shoebox 85:18 91:18
92:20
short 12:18 21:16 57:8
88:14 90:1,3 91:15
134:7
short-change 99:11
shortage 174:9
shortly 9:17
shortness 63:20
shorts 70:5
shoulder 151:1
show 29:10 144:22
190:7
showing 149:7 189:8
189:11
shows 76:21
shut 156:13
sickle 16:6
side 51:12 56:4 58:20
89:17 120:13 169:7
174:12 195:21
sign 143:1,5
signal 130:1,11
significantly 64:21
161:10,15,15 175:13
signing 198:17
similar 26:8 43:7 48:21
49:8 50:5,5
similarly 13:17 43:14
simple 31:11 86:2
123:21
simply 138:8 141:22

Simultaneously 116:2
single 18:4 19:16 57:20
104:4 132:3
single-patient 139:7
sir 133:21
sit 150:18
sits 151:7
sitting 101:17 193:8
situation 139:4
situations 185:4
six 61:18 147:21
skilled 95:8,10,16
sky 147:6
slide 8:1,12 11:1 19:22
23:4 24:14 25:22
34:18 51:9 52:16
66:22,22 67:5 69:5
82:6 96:21 135:21
206:20
slides 6:12,12 7:14
100:9
slight 172:11
slightly 14:21 46:6 79:9
small 4:10,12 48:4
61:16 158:3 169:20
195:7 198:18 203:5
203:14
SNF 187:9
sniff 36:14,17
social 23:7,18 24:5
29:15,18 43:12,19
51:19 66:2 73:21
107:6 113:6 114:11
116:4 117:4,7 122:6
122:16 137:11 156:3
158:14,17,19 159:3,9
159:11,21 168:10
170:6,11 171:20
174:7,13,15,18
175:11 176:14 177:16
182:1 185:17 190:19
191:2
softening 200:17
software 191:10
soldiers 186:21
solution 136:15 143:20
164:2 181:15 183:14
solutions 2:15 45:12
181:3,13
solve 136:11 144:1
172:15
somebody 58:17
144:21,22 145:1,1
159:13 163:14
someday 200:15,16
someone's 89:14 150:8
someplace 46:16
something's 75:1

soon 31:7 135:5 207:5
sooner 34:20 60:8
sorry 15:14 28:8,21
64:13 74:17 76:1
77:12 117:21 144:15
152:11 160:6,10
sorts 105:11
soul 138:18
sound 101:15 102:9
200:13
sounds 36:22 61:6
144:9 174:4
sources 175:5
South 173:10
space 137:5 142:3
145:7,7 173:2
spans 110:19
speak 26:7 126:3
141:10
Speaking 76:12
spec'ing 73:12
speced 103:10
specialist 10:8
specialists 179:11
specialties 167:6
specialty 150:22 169:7
specific 9:7,8 10:6
20:20,20 25:19 26:21
33:11 50:10 51:3 52:9
52:11 58:11 62:3,6,10
71:14 80:18,21 106:5
106:11,19 133:9
140:5 182:21 205:6
specifically 5:15 7:7,21
10:15 22:7 25:6 32:12
32:21 62:13 63:19
80:11 106:10,21
107:22 132:20 187:13
specifications 107:3
125:16
specifics 84:14
specified 49:22 50:6
specify 42:19,19 43:2
83:17
spelled 158:8
spend 176:5,5,12,14
spending 153:5
spent 11:3 53:20
129:12
spine 145:6
spirit 114:3
split 196:2
spoke 32:19,19
spokesperson 117:22
sprain 63:17
squares 202:8
squishy 161:7
stability 116:3

stabilization 56:7
stable 138:8,11
staff 2:17 24:1 135:3
 152:3 204:17 205:3
staffing 154:21
stage 154:12
staging 164:2
stakeholder 204:15
stakeholders 180:19,19
 181:2
stand 139:19
standard 41:11,14
 42:12
standardization 45:13
 136:4
standardize 123:2
standardized 16:12
 75:20 121:17 136:3
standards 41:7
standing 140:7
star 134:1 199:7
STARMER 2:8 38:10
 82:8 98:17
start 6:9 42:3 51:11
 59:2 62:22 85:1 110:7
 134:8 146:20 151:8
 151:21 152:2 179:1,2
 207:3
started 24:21 93:17
 102:20 125:14 134:14
 144:17 178:15
starting 118:14 151:11
 180:8
state 136:19 140:22,22
 174:12 194:16
statement 199:12 200:8
states 141:1 180:10
static 190:21
status 97:15 182:14
stay 93:17 200:2
STEMI 106:21
step 44:6 60:20 82:13
 92:8 93:6 112:19
 115:22 119:20 183:19
 203:16
Stephanie 2:16 43:6
 46:10,18 47:5 76:1
 77:11 88:9 152:14
Stephen 1:9,11 4:2
steps 92:13 202:2
Steps/Timeline 4:18
Steve 125:11 128:10
 134:15
Steve's 78:21
stick 31:4
stone 200:14
stop 84:22
straight 102:8

strategically 137:21
Strategy 2:1,12
stratification 57:3
 125:20
stream 198:10,11,15,17
Street 1:8
Strengthening 4:16
stretched 145:3
stroke 22:14,15 27:11
strongly 50:14 142:21
 145:17
structural 59:12 105:16
 106:1 108:7 120:16
Structurally 120:7
structure 22:11 40:21
 120:6 178:22
structured 42:1
struggle 92:15
struggled 126:16
 195:20
struggles 92:16
stuck 153:22
studies 54:16
study 149:6
stuff 116:18 139:17
 148:13 154:1 167:7
stumbling 137:7
sub- 61:16
subdomain 7:16 34:10
 50:20 70:22 96:7
 100:15 103:13
subdomains 7:7,11
 32:2 49:20 51:10 71:1
subjective 54:3
success 111:17
successful 2:7 16:11
 60:10 114:4
sudden 47:14
sufficient 94:17
suggest 80:8
suggested 69:20
suggesting 55:7
suggestive 177:2
summary 6:11 12:19
 103:1 104:11 111:6
 119:10 120:3 124:7
 203:11
super 138:6,19
superior 181:7
supplements 32:22
supply 85:17
support 28:18 35:9
 66:2 140:14 141:17
 164:19 175:6 195:3
supports 73:18 174:8
 174:15,22 175:11
 176:11,15
supposed 65:5,6 82:20

90:15,20,22
surgery 72:10
surprising 58:6
surrounding 95:13
survey 68:19 79:19
 141:12
surveyed 203:3
surveys 68:9 108:13
SUSAN 1:17
swath 142:12
swelling 165:8
swept 191:7
symptoms 106:12
 177:2
sync 193:1
synergized 153:18
syntax 186:13
system 3:3 16:20 17:4
 18:11,11 19:14,15
 21:12 43:9,13 46:18
 46:20,21 47:3,7,13
 48:5 69:20 76:6,7
 77:5 86:14 105:14
 106:5 108:11 127:3
 127:14 150:11 153:10
 153:18 154:6 155:1
 165:3,5 166:21 167:8
 167:9,21 168:6,8
 170:16 172:16 174:14
 174:21 176:17 178:7
 198:12
systems 2:15 3:2 22:2
 25:6,9,10 47:21 48:1
 48:2 59:14 74:19
 108:17 147:12 152:18
 152:20 156:17 167:13
 193:14 196:10 197:5

T

table 134:9 181:2 206:3
tackle 180:18
tag 110:2
tags 186:22
taken 22:13 27:10
 180:5
takes 14:7 29:10 113:4
 123:12 158:18
talk 21:19 47:12 68:6
 70:13 77:16 79:3 81:3
 97:2 128:9 135:10
 139:14 157:1 172:13
 175:10,14 202:9
talked 7:20 15:15 21:18
 24:4,14 37:5 46:17
 52:6 81:14 84:16
 94:14 97:8 100:16
 104:10,15 105:13,15
 105:22 106:13,15,22

107:21 110:15 116:16
 122:10,11 124:4
 127:10,21 149:3,5
 150:2 162:6 172:21
talking 13:20 18:5,9
 22:7 23:12 28:9 39:17
 39:18 40:1 42:7 46:19
 54:22 55:3,16 92:9
 94:10 99:1 131:8
 135:4,12 136:17
 138:16 148:9,11
 150:5 151:18 158:15
 161:3 163:4 168:9
 172:18,19 183:16
 190:12,22 192:2
 193:7
tape 187:12
target 101:12
Task 168:17
taxonomy 20:17 64:2
 106:8
taxpayer 180:6
TBD 12:21 203:15
team 13:20 31:16 32:6
 32:7,11 71:5 74:7,9
 74:12 93:9 102:3
 110:2 124:5,19 131:7
 131:19 137:18 150:11
 159:14
team-based 150:14
teams 138:3 182:6
technologies 192:4
technology 41:9 59:14
 135:18 139:12 182:22
 183:2 186:8 187:7
 190:9,14 192:19
 193:5 194:9 199:16
 199:18 200:17 201:2
 201:9
technology-related
 193:14
Ted 190:1
tee 111:8
tele-medicine 13:9
teleconference 3:4
tell 126:20 133:5 137:13
 190:10 194:4,4 198:4
 199:14 203:9
telling 85:11 138:13
 201:17
temperature 60:21
temporary 142:5
 145:11 159:5
tempting 157:20
ten 87:5 116:10 163:16
tend 60:7 61:20 154:16
 185:7
tended 56:12

term 21:16 88:14,14
90:1,21
terminal 107:1
terminally 22:20 107:2
terminology 130:18
terms 5:11,20 15:7
17:20 28:6 49:19 52:7
55:7 64:1 75:11,14
77:4 83:3 104:19
112:9 117:2 126:17
130:18 131:12 154:14
171:8,11 193:7 201:8
203:4,16 204:13
terrific 181:4
test 19:3,6,12,22 36:14
36:17 147:21
tested 64:16 108:18
testing 118:17
tests 9:17
thank 39:14 49:14
50:20 54:6 69:12,19
70:1 77:13 78:14 85:7
99:6 102:13 111:3
115:5 117:14 125:4
125:11 126:5 128:2
134:4 135:1,4,6 139:1
152:11,12 153:12
162:3 171:7 173:21
176:1 178:12 179:15
197:10 199:10 204:2
204:19 206:1,12,16
207:4,5
thanks 6:15 42:15
59:19 66:5 70:3 123:8
131:21 134:10,19
152:16 153:13
theme 37:13 53:15
73:17
themes 125:12,16
135:16,19 205:5
therapeutic 89:12
they'd 60:11
things 5:9,18 13:10
24:17 36:6 39:19,20
45:7 51:20 59:15 60:9
67:4 72:1 74:5 80:5
81:13 82:17 87:14
91:19 97:19 99:2
109:2 110:15,17
118:2,17 125:13
136:8 137:9 142:15
142:21 143:3,6,10
150:12 151:14 163:4
164:9,12 166:6
171:10 172:6,19
177:16 178:6 179:7
182:11 186:12 188:11
189:2 191:4 194:19

197:9 201:5 202:10
third 60:1 101:9 132:16
133:2
thought 5:8 6:22 8:15
8:22 10:20 15:21 19:7
20:2 24:16 40:12
53:20 58:13 71:12
98:15 104:1,6 106:18
108:6,22 109:6,14,14
118:19 120:8 132:13
146:3,3 201:10 203:9
thoughts 28:3 34:18
98:12 134:20 146:9
threading 21:4
three 24:20 57:6 58:21
59:5,10,16 61:17 71:1
71:2 72:2,3 94:3
100:7,10 155:11
156:3 157:6 163:10
192:5 196:15
throw 139:3
thrown 155:10
thumb 187:12
Tier 187:22,22,22,22
time- 177:5
time-ready 164:2
time-sensitive 111:22
112:4
timeliness 7:22 109:13
timely 31:10 71:8
times 60:6 62:15 68:3
94:3 121:5 138:9
156:8 157:13 159:16
179:18 183:1 185:17
188:7
timing 11:9 84:10
tired 202:10
to-face 151:10
today 5:5 7:1 10:21
25:9 72:1 74:6 118:19
158:15 202:16 203:8
today's 202:15
told 58:3 60:10
tonight 201:11
tons 200:5
tool 186:8
tools 42:9 121:17
155:20
top 85:18 188:22
top- 197:6
topic 197:17
toss 56:12
total 183:14
totally 24:13 132:1
164:13 167:1 176:3
touch 128:6 166:11
207:5
touched 182:22

tough 83:21
track 69:19
traditional 116:8
traditionally 28:15
161:19
traffic 201:8
trained 159:1
transfer 9:14,14 25:5,7
51:1 109:1,13 124:8
176:16 193:19
transferred 9:4 10:3
20:13 23:2 107:15
transferring 92:10
107:1
transfers 12:13 95:7
192:15
transformed 154:22
transition 7:10 9:13
10:15 12:5 14:4 19:16
20:11 46:4 48:7 49:21
55:20 56:10,19 57:22
61:2 79:18,20,22 80:9
80:13 81:16 86:22
87:16 88:2 89:18
94:12 95:14 97:14
99:1 100:5 104:1,5
108:1 111:18 112:7
113:11,14 114:4
121:15 122:15 126:2
148:11 165:21 166:15
166:18,19,20 167:3
168:11 170:9 171:15
transitioned 39:1 149:8
transitioning 131:16
transitions 1:3 7:19
8:16,19 10:16 12:7,9
20:5,5,18,19 42:6
43:9 45:19 46:6 47:13
48:22 49:3,6,7 52:13
90:6 97:17 104:4,8
108:9,12 147:19
148:6 149:12 151:5
162:15 165:22
translation 37:21
transmission 108:3
123:22
transmitted 22:9 38:18
Transplant 200:4
transportation 191:3
transported 187:11
trauma 162:12
treat 92:10
treat-and-release 114:5
114:7,10
treated 155:9
treatment 19:12 22:15
165:20 181:12
tremendous 191:20

TRICIA 1:16
tried 40:20 87:9 109:22
121:18 170:14
trigger 69:21
triggers 81:19
trip 206:17
true 48:17 56:2 82:14
167:15 177:12 186:4
truly 23:15 45:18
try 70:13 83:19 119:9
121:13 122:13 129:11
139:12 143:6 154:1
166:1,20 177:16
179:9 197:1
trying 25:14 40:16
46:22 55:18 56:11,17
61:8 62:22 63:3 66:8
73:17 82:21 88:7
129:5,15 130:5,10
131:12 139:17 162:14
168:16 172:3 176:8
178:1 197:7 201:14
tumor 172:7
turf 97:18,20
turn 201:22
Turnabout 109:16
turned 112:20 195:22
turnover 31:3
tweak 71:16
tweaking 7:5
twice 61:16
two 7:11 8:21 14:12
22:16 32:5 39:3 45:7
51:10 58:15 71:1
72:13 74:4,5 84:21
92:13 103:8 108:6
110:9 111:15 116:11
118:2 134:22 136:21
150:1 156:22 165:13
172:4,19 177:19,20
202:18
type 37:6 39:10 51:21
68:18 118:6 130:15
147:6 152:9 153:19
types 17:9 20:18,19,20
32:5,9,22 33:16 39:12
51:2 52:7,14 99:4
typically 94:20,22 95:9

U

ubiquitous 14:4 25:12
UCSD 1:15 189:22
UHS 1:21
ultimate 7:15 8:2 96:19
ultimately 6:20 19:6
20:22 190:12
umbrella 122:14 144:18
unable 163:2

unconnected 169:18
uncontrolled 59:5
under-resourced 170:6
under-utilized 117:1
underestimated 158:6
underneath 168:3
understand 27:16 38:3
 44:2 49:2,3 60:3,7,14
 65:20 80:4 82:3 89:19
 90:21 95:19 101:21
 113:12 114:2 139:10
 142:16 149:20 152:21
 153:1
understandable 114:22
understanding 17:12
 37:22 51:19 68:20,21
 69:14 78:13 83:3
 84:18 89:3 96:18
 112:17 119:20 124:16
 128:22 139:8 140:9
 141:8 156:10 172:18
 174:19
understands 65:4
understood 67:20,22
 80:1
underused 192:3
underutilization 97:6
undifferentiated 163:12
 165:7
undue 21:3 55:7 56:1
unfortunately 6:17
 117:20 134:16 163:6
 186:8
uniform 39:13 192:22
unintended 174:17
unique 110:18 178:10
unit 166:18
United 180:10
universal 140:19
 141:20 142:1
University 1:11,14,18
 1:22 2:13
unmet 122:6,16
unnecessary 156:6
unplanned 163:7
unresolved 110:6
unscheduled 165:2,19
 166:3 176:22 177:4
untapped 154:5
upcoming 202:12
update 71:1 191:2
updated 72:20
updating 73:2
upkeep 186:10
upload 142:2
uploaded 145:4 146:18
upper 191:8
ups 37:7

upstairs 40:2
upstream 44:3 185:16
urgent 17:10 18:18 19:5
URI 55:5
usable 114:22
use 50:22 61:15 80:2
 87:12 131:20 170:15
 171:10,13 183:7
 187:6 191:19 192:4
 197:22 201:5
useful 7:19 18:22 19:17
 20:3 70:20 71:7,12
 170:14 186:16
user 2:1 138:6 188:20
users 16:4 61:21
uses 198:2
usually 9:8 41:12 57:3
 68:10 123:14 195:15
utility 16:1
utilization 79:11 97:9
 140:10

V

vacation 68:4,16
vague 5:19
vain 26:8 43:8
validity 41:1
valuable 24:17 87:20
 190:4 191:5 194:5
value 194:15
VANESSA 2:19
variable 43:3 191:3
variables 42:20
varied 12:21,22
variety 16:5 178:6
various 72:9
vast 54:22 61:15 87:3
 143:13 197:21
vendor 48:10
VENKATESH 2:10 40:8
 55:11 77:18 86:11
 128:12,21 129:9
 164:11 176:2 193:13
 197:16
verbal 78:19
verification 33:20 34:22
 52:4
verify 43:22
versus 133:1
vessel 22:12
Veteran's 1:18
Vice 2:4,19,21
victim 132:6
victims 23:21
video 156:18
view 145:2 164:9 167:4
 199:13 206:17
virtually 167:9,19

184:19
vision 140:1 146:11
 158:8
visit 9:21 10:1 11:13
 12:16 13:3,3 29:5
 37:6,12 54:11,17
 56:20 57:20,21 58:4,8
 58:10 59:10,22 61:9
 63:8 76:10 78:7 80:16
 80:22 96:10 105:6
 128:19 131:2,2 132:3
 161:4 162:1
visitation 129:3,4,6
visited 160:18
visiting 107:2 128:17
visits 55:22 57:2 58:3
 58:16,22 59:5,16 66:9
 66:15 69:22 76:5 96:6
 104:14 127:6 130:7
 130:10 131:13,15
 163:7 170:11 172:4
 193:18 200:4,5

vital 16:19
volume 59:6 162:19
vulnerable 121:22
 138:19

W

wait 163:10 174:6,7
 177:19,20 195:6
waiting 152:14 162:4
 174:1
walks 30:6
wall 46:12 109:1
wanes 161:10
wanted 34:5 78:17 97:5
 99:10 134:15,19
 142:2,4 148:6 158:21
 197:12
wants 79:2 164:6
wards 161:20
warfarin 89:22
Washington 1:8 191:7
wasn't 100:3 159:3
wasteful 154:17 156:5
way 17:18 29:20 35:12
 38:21 44:4,6,13,19
 56:14,16 59:1 67:16
 67:20 68:22 70:9 86:5
 93:6 114:2,20 119:4
 130:21 131:16 138:10
 139:19 153:7 157:22
 163:18 164:22 165:18
 168:12 170:13 176:11
 180:7,18 182:14
 185:2 191:13 194:13
 197:3,6 198:7
ways 12:4 28:17 38:11

69:16,19 87:19
 178:14 189:14
wear 186:21
web 120:14
webinar 203:20,20
 205:1
WEDNESDAY 1:5
weed 100:21
weeds 135:9
weedy 45:22 46:9
week 133:12
weeks 165:13 166:2
 177:19,20 203:5,15
Welcome 4:2 5:4
went 8:14 32:12 55:4
 59:18 60:21 100:1
 102:17 103:7 125:13
 126:12 186:18 187:13
West 2:7,14 66:7
Western 2:15
WESTON 2:14
what' 90:14
wheel 45:14
wheeled 29:9
Wheels 124:12 138:4
 169:16,17,19
white 154:3 162:6
Wilson 2:21 4:8 13:19
 17:20 18:9 37:17 45:7
 52:20 77:16 78:14
 82:22 94:7 99:6,9
 102:19 125:11 128:20
 129:8 131:3,7 204:4
 206:22
win/win 174:21
winding 197:13
wing 157:9
winnowed 32:2
WITWER 2:16 43:7 76:2
 88:10 152:16
wonder 82:18
wonderful 153:18
 162:12 186:8
wondering 26:11 71:15
words 134:15
wordsmithing 107:4
work 5:7 21:2 41:21
 42:21 43:3 58:2 64:1
 64:9 76:21 78:9,16
 79:17 84:1 100:2
 102:12 105:15 106:3
 108:6 127:17 130:2
 134:20 149:1,7,8,9,11
 149:22 152:5 159:7
 159:14 162:8 163:16
 163:17 164:14,16
 167:7 168:10,18,21
 169:6 170:11,22

171:20 172:3 183:10
 184:9 200:8 203:12
 206:6
work-up 163:12 172:10
worked 44:15 99:17
 121:12
worker 158:19 159:3,9
 159:12,13,21 161:14
 185:17
worker's 158:18
workers 117:7 137:11
 156:3 158:14 160:3
 177:16 182:1
working 14:7 35:4 64:5
 145:15 153:10,17
 179:3
works 141:11 168:12
 169:2 181:12 184:9
 187:20
world 116:9 129:16
 130:3 163:9 164:16
 164:18 166:14 168:5
 168:21 178:2 194:8
 198:14 199:17
worry 15:7,8 67:15
worse 132:5
worth 75:15 99:5
 169:10
worthwhile 126:11
 131:5
wouldn't 20:15 80:2
 142:13
wound 36:1,17 114:6
woven 34:11
wrench 151:20,20
wrenches 151:19 152:3
write 154:3
written 78:19 79:5
wrong 77:8 133:6 150:9
wrote 58:12

X

X 122:19,20 133:11
X-ray 172:7

Y

Yale 2:13 129:10
year 40:17 58:3,5,8
 136:21 170:4
years 31:2 64:10,15
 116:11,11 157:6
 159:20 168:17 169:1
 181:6 190:5 192:5
yelling 201:16
yes/no 120:9 121:2
yesterday 5:7 6:11 32:2
 46:11 53:5 73:10
 77:19 78:5 87:3 101:1

101:4 102:12 112:14
 118:19 124:4 149:6
 169:12

Z

zero 62:22 127:9

0

0291 9:1

0297 9:1

1

1,000 185:14

1.2 58:3

1.3 58:3

1:25 207:7

10:01 102:17

100 127:9 206:19

102 4:10,11

103 4:12

1030 1:8

11:00 6:3

11:15 102:9,10

11:23 102:18

11:54 134:11

12:15 134:8

12:17 134:12

12th 205:2

133 4:13

134 4:14

135 4:16

15 30:11 53:1 79:19

80:8 81:6 189:19

15th 1:8

16 189:20

17 181:6

18 122:1

1976 163:19

199 4:17

2

2 187:22

20 123:15 133:6

2017 1:6

202 4:18

207 4:19

20th 153:22

24 6:20 8:14 10:9,10,19

22:2 104:13

24/7 119:2,4 171:19

178:5

24/7/365 154:12

26 1:6 4:6

26th 202:15

3

3 187:22

3:00 154:13

30 123:15 161:11

4

4 187:22

47 149:9

4th 203:21

5

5 4:2

50 138:9

50-year 55:3

53 149:8

6

6 4:4

60 9:8 59:1,7,16 68:10

60/40 196:3

65 122:1 132:11 175:20

7

70 4:7

72 10:12 105:4

75 162:10

77 4:9

8

8:29 5:2

8:30 1:8 5:4

80 133:5

85 162:10

9

9:30 5:22,22 8:7

90 59:1 193:8

911 156:15,16

99.9 115:13

9th 1:8

C E R T I F I C A T E

This is to certify that the foregoing transcript

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

Before: NQF

Date: 04-26-17

Place: Washington, DC

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



Court Reporter

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS

1323 RHODE ISLAND AVE., N.W.

WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com