NATIONAL QUALITY FORUM

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EMERGENCY DEPARTMENT
QUALITY OF TRANSITIONS OF CARE EXPERT PANEL

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WEDNESDAY
APRIL 26, 2017

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

PRESENT:

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

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

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

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
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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

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

8:29 a.m.

CO-CHAIR CANTRILL: Good morning. It's 8:30. Welcome back. We have quite an extensive schedule today. In fact we've made a couple of changes.

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

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

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

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

into our breakout group.

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

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

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

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

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

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

could be potentially used today.

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

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

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

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

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

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

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

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

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

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

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

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

this NQF 0291 to 0297.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

metric.

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

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

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

And also similarly, medication reconciliation. Yes, Marcia?

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

Is, as Jesse's going through these,

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

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

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

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

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

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

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

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

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

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

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

And we think that that is sort of a key potential area for measure development. Where, you know, those programs have been particularly successful in being able to deploy sort of a standardized care pathway for a patient who comes into the emergency department frequently, and one that is actually coordinated with a primary care medical home with the primary care physician.

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

education or different expectations across settings.

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

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

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

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

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

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

DR. PINE: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

Which I think is ultimately what we

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

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

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

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

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

About having accessibility of pre-

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

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

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

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

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

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

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

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

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

referral by ED staff. Janet?

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

DR. PINES: Yes.

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

DR. PINES: Yes.

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

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

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

There were really no measures around

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

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

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

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

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

I think that was all of the group. Yes. Yes.

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

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

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

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

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

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

community.

MS. COBB: Okay.

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

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

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

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

DR. PINES: Yes.

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

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

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

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

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

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

MEMBER RHODES: So, I think in this

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

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

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

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

And then so it maybe moves to outcomes

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

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

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

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

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

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

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

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

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

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

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

MS. COBB: Okay. Good morning. So,

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

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

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

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

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

be as part of a med-rec list.

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

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

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

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

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

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

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

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

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

CO-CHAIR CANTRILL: Brenda?

MS. COBB: Or even sooner.

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

include the patient preferences? The patient's goals?

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

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

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

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

MS. COBB: Okay.

MEMBER SCHMITTHENNER: Because they maybe very different then --

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

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

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

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

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

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

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

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

(Laughter.)

MS. COBB: Doesn't take too long.

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

MS. COBB: Okay. Sounds good. Okay.

Anymore comments? Karen?

CO-CHAIR CANTRILL: Marc?

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

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

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

CO-CHAIR NILES: Microphone?

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

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

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

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

CO-CHAIR CANTRILL: Amy?

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

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

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

transitioned.

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

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

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

CO-CHAIR CANTRILL: Janet?

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

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

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

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

CO-CHAIR CANTRILL: Arjun?

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

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

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

the validity of reporting.

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

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

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

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

to capture that data in a structured format.

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

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

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

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

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

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

Stephanie?

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

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

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

information that's already there.

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

CO-CHAIR CANTRILL: Joe?

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

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

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

departments?

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

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

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

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

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

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

patient we need this element. For this patient we need this element.

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

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

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

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

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

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

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

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

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

CO-CHAIR CANTRILL: Jesse?

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

And you know, for the most part most

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

There are a series of meaningful use

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

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

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

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

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

So, I think we -- some revisiting

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

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

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

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

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

DR. WILSON: No, no, no.

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

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

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

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

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

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

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

And I think, you know, in general we

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

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

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

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

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

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

patients that would be eligible for a measure like this.

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

MS. COBB: Yes. Absolutely.

CO-CHAIR CANTRILL: Arjun?

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

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

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

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

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

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

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

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

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

It may often be an acute exacerbation

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

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

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR CANTRILL: Thanks Arjun. Karin?

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

third.

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

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

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

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

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

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

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

So, trying to prevent that second ED visit.

CO-CHAIR CANTRILL: Elif?

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

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

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

CO-CHAIR CANTRILL: Aleesa?

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

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

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

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

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

CO-CHAIR CANTRILL: Jesse?

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

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

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

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

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

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

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

CO-CHAIR CANTRILL: Brenda?

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

CO-CHAIR NILES: Pull your mic down.

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

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

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

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

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

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

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

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

CO-CHAIR CANTRILL: Thanks Brenda. Sam?

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

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

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

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

CO-CHAIR CANTRILL: Marc?

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

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

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

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

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

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

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

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

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

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

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

that.

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

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

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

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

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

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

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

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

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

Kirsten, you're up next.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So, Jim?

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

CO-CHAIR CANTRILL: Any other

comments? Oh, sorry. Stephanie?

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

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

CO-CHAIR CANTRILL: Aleesa?

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

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

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

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

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

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

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

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

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

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

I think the question we asked right

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

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

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

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

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

retrievable.

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

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

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

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

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

patient understood.

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

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

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

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

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

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

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

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

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

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

And I made a note of paired measure.

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

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

CO-CHAIR CANTRILL: Amy?

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

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

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

DR. WILSON: That's interesting. And

we can take that back to the group this morning.

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

CO-CHAIR CANTRILL: Jesse and then Julie.

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

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

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

You know, and I think that the kind of

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

CO-CHAIR CANTRILL: Julie?

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

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

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

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

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

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

CO-CHAIR CANTRILL: Thank you. Aleesa?

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

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

Medication reconciliation is a big

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

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

CO-CHAIR CANTRILL: Good point. Arjun?

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

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

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

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

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

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

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

And so I'm interested to know, and

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

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

CO-CHAIR CANTRILL: Stephanie?

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

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

CO-CHAIR CANTRILL: Brenda?

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

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

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

CO-CHAIR CANTRILL: Nicki?

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

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

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

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

CO-CHAIR CANTRILL: Marc?

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

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

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

CO-CHAIR CANTRILL: Karin?

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

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

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

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

they have renal failure or whatever.

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

CO-CHAIR CANTRILL: Julie?

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

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

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

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

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

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

CO-CHAIR CANTRILL: Brenda?

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

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

CO-CHAIR CANTRILL: Marcia?

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

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

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

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

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

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

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

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

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

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

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

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

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

Okay. We had some gaps. We realized

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

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

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

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

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

like to kind of expand on what he said.

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

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

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

CO-CHAIR CANTRILL: Amy?

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

I don't know to what extent you were

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

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

CO-CHAIR CANTRILL: Yes.

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

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

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

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

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

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

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

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

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

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

There were a lot of great ideas that

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

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

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

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

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

And I also think by doing that you get

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We also talked about a potential

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

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

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

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

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

We did a little bit, we talked a

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

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

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

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

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

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

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

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

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

wall time, ambulance transfer time?

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

(Laughter.)

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

CO-CHAIR CANTRILL: Turnabout is fair play.

Any other comments?

(No response.)

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

MS. COBB: I tried to pass this off

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

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

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

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

So I will -- sort of that is the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

patient?

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

MEMBER CARDEN: Okay, thank you.

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

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

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

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

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

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

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

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

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

CO-CHAIR CANTRILL: Elif.

MEMBER OKER: So to that point I'm

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

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

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

(No response.)

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

MEMBER MASSEY: Unfortunately --

CO-CHAIR CANTRILL: Sorry, Julie.

MEMBER MASSEY: -- our spokesperson

isn't here.

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

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

department.

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

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

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

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

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

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

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

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

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

We recognized our vulnerable

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

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

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

community that didn't exist.

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

CO-CHAIR CANTRILL: Thanks, Julie.

Any questions or comments? Joe.

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

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

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

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

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

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

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

CO-CHAIR CANTRILL: Thank you, Julie.

Any other questions of comments concerning this?

(No response.)

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

DR. WILSON: Okay. Thank you, Steve.

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

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

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

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

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

up.

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

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

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

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

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

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

DR. WILSON: Right.

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

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

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

DR. WILSON: Yes.

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

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

a signal for care coordination.

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

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

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

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

DR. WILSON: Yes.

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

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

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

CO-CHAIR CANTRILL: Thanks, Marcia. Jim.

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

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

CO-CHAIR CANTRILL: Jesse.

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

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

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

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

(No response.)

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

OPERATOR: Yes, sir.

At this time if you would like to make

a comment, please press star then the number one.

And there are no comments at this time.

CO-CHAIR CANTRILL: Thank you, Operator.

With that we will adjourn to lunch, a short lunch. Pick up your lunch and come back. Yeah, we're going to start at 12:15. So you can eat at the table. It's accepted.

Have a nice lunch. Thanks.

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

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

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

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

CO-CHAIR NILES: All right, thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

to execute on our vision. Brenda?

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

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

CO-CHAIR CANTRILL: Karin.

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

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

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

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

CO-CHAIR NILES: Aleesa.

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

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

CO-CHAIR NILES: Andrea.

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

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

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

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

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

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

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

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

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

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

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

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

to somebody, share it with somebody.

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

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

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

CO-CHAIR NILES: Definitely something for more discussion.

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

MEMBER PRICE: So --

CO-CHAIR NILES: Oh, it's Marc. Okay. I thought it, I thought it was -- Okay, go ahead.

MEMBER PRICE: I can be her if you like.

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

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

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

And there may be some overriding thing

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

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

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

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

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

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

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

It has to be realistic in the fact

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

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

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

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

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

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

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

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

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

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

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

So, thank you. Sorry for my rant.

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

Stephanie, you've been waiting patiently.

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

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

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

CO-CHAIR NILES: Thank you. Jim.

MEMBER DUNFORD: Thanks for having another chance.

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

and then try and fit all this stuff into it.

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

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

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

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

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

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

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

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

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

In Houston they've got two ER doctors

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

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

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

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

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

CO-CHAIR NILES: Great.

Joe, you have something?

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

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

mean, they're trained to actually do that.

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

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

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

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

CO-CHAIR NILES: Yes.

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

CO-CHAIR NILES: Absolutely.

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

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

CO-CHAIR NILES: Of course.

MEMBER KARAN: Of course.

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

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

were discharged from the ED.

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

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

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

CO-CHAIR NILES: Great. Thank you.

Aleesa, you've been waiting patiently.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR NILES: Thank you. Karin.

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

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

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

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

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

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

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

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

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

CO-CHAIR NILES: Thank you.

Let me get to Brenda. Brenda has been

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

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

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

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

that are in the community really are important.

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

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

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

CO-CHAIR NILES: Thank you.

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

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

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

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

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

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

And so, the other thing that we could

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

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

CO-CHAIR NILES: Thank you. Julie.

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

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

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

CO-CHAIR NILES: Great. Thank you. Jim.

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

So if you really look to see where the

majority of the care coordination and patient care that happens for the most expensive people in your city, it's really they are being managed by the police department and being put in jail and taken out of jail. And so it's really a form of cost shifting to the taxpayer in a different kind of way.

And this is actually really starting to blow up. I mean, fire departments around the United States -- fire chiefs are apoplectic about this, about this issue. Police chiefs are apoplectic about this issue, about the fact that they are managing chronic mental illness and bringing them repeatedly to emergency departments for medical clearance again and again, and filling up their jails.

So, really, just in the idea of if we really want to tackle this the right way, who are the stakeholders again? The stakeholders are the people that are actually just as bummed out about how bad it is as we are. And there are very few affiliations that you find really meaningful

associations where you really bring those kind of community stakeholders to the table and actually come up with solutions.

We have a terrific program for chronic homeless alcoholism in San Diego that's been operating for 17 years, where it's a partnership between the superior courts and the police department, the fire department, the emergency departments, the public defender, you know, everybody. And it really moves people into a choice between, frankly, incarceration or treatment. And it actually works.

So, those kinds of solutions, you know, to chronic homelessness, there was no other solution until you really engage those kind of people. And I think that that's the hard part for emergency departments, who are the front door to all these issues, we are the -- we're dealing with those people -- is to kind of get a knowledge and expertise in the emergency department of what's going on out there. Really the bottom line, with all due respect, most

hospital social workers don't know what's going on downtown. They know the names of the facilities but they don't know the people. And the connections really have to be built.

So, that's my pitch, is to create more of kind of a -- you know, interdisciplinary teams is where EDs are actually collaborative. And this concept of when you -- since hospitals, according to the Accountable Care Act, have to do these community assessments and periodic needs analyses, that those are the kinds of things that they prioritize for their programs. And that they really -- if they're going to maintain their nonprofit status, that this is the way they do it, through these kind of collaboratives, rather than just saying, well, you know, I have pediatric asthma in the community and we need to get the mold out. Everybody knows that.

CO-CHAIR NILES: All right. So we've heard a lot of barriers. Do we have -- we had some specific policy recommendations. What about the role of technology? I know we've touched on

that a couple of times. What is the role of technology? And if there is a role, what is it? Julie.

MEMBER MASSEY: I think it's an enabler. It's some of the found -- when you have some of the foundational elements with the push towards incentivizing for meaningful use. We've got some of our information where it needs to be to be able to move to that next level. But we have a lot of work we still need to do to optimize that.

We've got to move very quickly. It's a foundational enabler. I don't think it can be this total solution to the issue but it's something that has to enable the rest of what we're talking about.

CO-CHAIR NILES: Joe.

MEMBER KARAN: It's also the gateway to the patient's next step when they receive -- they leave the emergency room. It's -- on IT you're looking at all the programs that are available that can be found. Are they difficult

to find? Sometimes. Because IT's not perfect. But everything that the emergency room would need -- I'm not saying for nurses or physicians -- I'm just saying everything the emergency room would need to take that patient and release that patient into the community exists. It's not new, it's already there.

The problem is finding it, dissecting it to see what works and what doesn't work. That's not there. Everything's there en masse.

But -- and also if I can -- when the patient's leaving the emergency room and the comment you get is -- you ask them about the cost of drugs, can they afford it? And let's say the answer is no. What happens at that point in the emergency room? Does something else happen, for example, that they know that numerous pharmaceutical companies have low-income programs for virtually every medication that's out there.

Is that information given to the patient or not? I mean, I don't know. It would help the patient I think -- to gather it, yes.

That's why I think that pre-gathering information is the best way to do it, if we can. But, you know, in the emergency room there's such a breadth of situations.

CO-CHAIR NILES: And to back it up a little bit, to build a little bit on what you're saying, when you ask -- I tend to caution people never to ask a person if they can afford their medication because, number one, they don't know what it's going to cost. And a lot of people will always say, yes, of course I can afford that.

A better question might be, you know, if this medication costs $1,000, what are you going to do about that? So that's one thing to kind of back it upstream because -- and many times the physician or the social worker or the nurses in the ED -- if there's not a clinical pharmacist there, they have no idea what it's going to cost. And they have not accessed the payer's formulary to know if it's even on the formulary or whether it will be covered or what

it's going to cost.

So there are a lot of little nuances there that I think we've really got to address to make that come true for what you were saying. I agree.

Aleesa.

MEMBER MOBLEY: Yes, as far as technology, wonderful tool. Unfortunately, the barriers are it costs a lot of money, and it costs a lot of money for the upkeep. It has great promise. But many of us assume it can do things magically. It can't do everything without the correct input, such as syntax, language. Lots of data goes in, but there has to be some commonality to pull that data out to make it useful.

And while I was going through all this, the little lightbulb went off for some aspiration. For those high-risk, high-acuity patients who are in and out of your emergency room all the time, we have soldiers who wear dog tags all the time. We have elderly patients with

medical alert bracelets on for their allergies. Can we get those patients some kind of grant so that we can get them a little flash drive bracelet so that all of their health records are right there?

CO-CHAIR NILES: Great use of technology, yes?

MS. COBB: I would actually just say we did a key informant interview with a SNF, and they were actually doing that. When they transported folks to the ED they would, you know, tape a thumb drive or have a certain information packet that went specifically with them. Analog, you know, yeah.

CO-CHAIR NILES: Okay. Amanda.

MEMBER PEARSON: I think -- going to the point on the prescriptions, I know some EMRs have that capability. So when I prescribe medications -- and it's not all the time, so I don't know why it works for some patients and not others -- but I'll get a list of this is level -- this is Tier 1, Tier 2, Tier 3, Tier 4, not

covered on your formulary. And it will sometimes even give me the cost. Other patients it's not there.

But I think that those -- there are capabilities that are available that can be built in. And I think it is helpful because a lot of times you're choosing among multiple medications, and it doesn't matter if I prescribe medication A or medication B to me, but to the patient that's going to matter quite a bit. And so I think that those are things that we could build in as potential quality aspects and encourage our EMR friends to flesh out a little bit more.

I think one of the other big benefits of the EMRs are the capabilities to have little preset reminders and pings. And I know that there is always the risk of too many pings and alarm fatigue, and you just ignore them. But then there is also the -- you know, there is also -- when a high user or a high-risk patient comes into the ER, maybe there's a little red box at the top of the screen that flags this as a high-

risk patient.

Or maybe there are things in the EMR where when you discharge a high-risk patient, if that patient hasn't seen their primary care or if a prescription hasn't been filled, maybe a notification goes out to their primary care provider, or a notification goes out to the patient like this -- our record is showing that this prescription was not filled. You did not pick this up. Like, reminder to do this. Or, we're showing that you did not see your physician. Reminder to contact your physician.

I mean there's -- I think there's a lot of different ways that EMR can be helpful to us that we really haven't developed.

CO-CHAIR NILES: Jim.

MEMBER DUNFORD: We were very lucky in San Diego because we were one of the Beacon communities. So we got whatever that was -- $15 or $16 million -- that came to kind of build an HIE. And, fortunately, the PI on the grant was the Chairman of Emergency Medicine at UCSD, a guy

named Ted Chan.

So I got to have a certain amount of input into the thing, including the idea that EMS bidirectional exchange would be a valuable thing. So we've been building toward that for years.

And now we just got an ONC grant that is now going to show the ability to send alerts, file and reconcile records. So it's called SAFR technology, which actually allows you to actually impart the record permanently, tell the -- you know, live feed information from the field. And then ultimately, as we were talking about, get information back.

So the technology is there. I mean it's so critical that we all kind of expand the idea of, you know, bidirectional HIE access.

Everybody probably knows the Academy of Medicine recently identified I think it's nine social determinants that should be incorporated into the electronic health record. So that's coming. Some of those are very static and some of them are dynamic. So we're really talking

about the emergency department's ability to kind of update social determinants, you know, like availability of transportation and more variable things. I think that's really going to be valuable.

We recently had demonstrated a program that has swept across Washington, Oregon, and upper California called EDIE. And I think if you just look at an example, I think it's the only software that ACEP has officially endorsed. But it carries the care coordination plan for a patient -- complex patient. It began basically as a way to kind of address pain-seeking patients, and it expanded to something much broader than that. But it has the ability to share the care plan to every emergency department and, really, probably across the entire HIE.

So HIEs can build these or they can use this and take at least a look at what that does because it is a tremendous asset to being able to find out, you know, what the management plan is of the primary care physician.

And the other thing is alerting, too, as Andrea was talking about, I just feel like we have really underused the concept of alerting technologies. You can use them in the field to alert. We, three or four years ago, were alerting case managers on patients that were, you know, high-risk patients to let them know they were en route to the ER, so the EMS providers were letting them know to come and see that patient in the field.

And this concept of the ADT alert, you know, when a patient comes into the emergency room and the patient's officially admitted to the ED, that thing has all kinds of -- and there are millions of transfers being executed all the time in HIEs that the EDs probably haven't really adequately harnessed.

So I just think that, you know, that the technology that's inherent in this whole thing is going to drive all this. I'd just get back to, like, what everybody was saying, there's privacy issues and lack of a uniform medical

record number to be able to really sync it all together. Otherwise it's just probabilistic matching and it can be complicated.

CO-CHAIR CANTRILL: Right. And I think technology has to be used intelligently, not just used. And that's a problem, certainly as you're talking about alert fatigue in terms of the guys sitting in from of the CRT for 90 percent of the time. That is pretty mind-deadening and it leads to complete ignorance and ignoring of the alerts.

Arjun.

MEMBER VENKATESH: I guess it's sort of technology-related but, so systems like the EDIE information exchange, this idea of having a care plan they could follow, or at least the ability to have some key information about emergency visits, hospitalizations, care providers that transfer people. It has been implemented in several geographies.

I would say the challenge of all of those -- and this from a management policy

perspective -- is that there's no business case for something like that which has a huge clinical case. And so you would ask, any clinician will tell you, and even patients will tell you, yes, I think it would be so valuable if you had that information about my care. And every clinician says, I absolutely need that information. But in our current world, the investment in new technology or a new IT is a largely hospital-based investment. And there's actually no hospital business case to invest in these EDIEs.

There may be in some very peripheral, indirect way in a huge future when hospitals change how they get paid. And if they're taking population-based payments it might have value. So in a state like Maryland where they've got a global budget, there might be some business case for them to invest in it. But even that, when there's so many other things to invest in, it never gets done.

So, I think there's this important point to be made that there are certain amounts

of information exchange and information availability in HIE that you almost need to create a regulatory support for, or say that it is in the public good and it is necessary in order for us to actually provide care coordination and not wait for the business case to exist. For small segments of healthcare to be able, it's never going to happen. They're not going to invest in it.

CO-CHAIR CANTRILL: One more point. A lot of this information needs to be pushed, not pulled.

The PDMP is a good example of how if you have information that has to be pulled, it usually will fail.

CO-CHAIR NILES: Julie.

MEMBER MASSEY: So it's very interesting. In the Philadelphia area and their HIE approached this a little differently. Because they struggled with the same thing: there was not business care for the hospital side. What they turned to was to say who in our

community is benefitting?

And they actually split the cost, and I think it was 60/40, to the payers. Because at that point the payers had the information and could be the conduit to notif -- to identify who needed to be notified because they were the only ones. They know who they're paying bills for. And they were -- so there's a combined, shared in that cost between the payers and the large hospital systems who had a choice to buy in. And then individual providers could contribute at a different kind of a rate.

So, it was an interesting approach. Took a long time to do. But they did pick their three main payers to be the receivers of that ADT fee, and the notifiers that if their directory became the notification to say who's the main provider responsible who's been getting billing for the care for this patient?

CO-CHAIR NILES: Amanda.

MEMBER PEARSON: You sort of echoed what I was thinking that, you know, there is not

a business case now but how do you try and make the business case? And the payers seem like the most logical way to do that, unless the payers and then the hospitals are going to change their systems to follow the money. And maybe that's the way to get around this, rather than just top-down trying to force the hospitals to do something to make it in their interest and with the benefit of improving things for patients.

CO-CHAIR NILES: Great. Thank you.

Other comments? Marcia, do you -- are we getting where you wanted to go? Yeah, I think that we are winding down here a little bit.

Do we have any other comments? Oh, Arjun.

MEMBER VENKATESH: If we're on the topic of IT, there is one, it is like a, maybe it's a personal gripe, but there is one actually very near-term, feasible obstacle to effecting care coordination and quality measurement in the emergency department, and that is that the vast majority of emergency departments use a different

EHR product for the ED than what the hospital uses.

And so one of the primary challenges, I'll tell you, in deploying the electronic health record registry, the ACEP CEDR, the clinical emergency data registry for quality measurement, is that the only way to be able to do quality measurement of hospital-based care is you have to have permission from the hospital to the data stream from the hospital, and permission to the data stream from the clinicians.

And we have currently a system in which the current policy incentives and business case incentives will create a world in which you can get the data stream from the clinician, but the hospital's not particularly interested in signing off that data stream.

And so there is a small interoperability data exchange need there between -- and recognizing that when you have non-hospital-employed clinicians and hospitals separate that you've got to, you have to -- both

of them have to share. Hospital-based clinicians have to be able to get at this hospital data.

CO-CHAIR NILES: Operator, could you open the line to see if we've got some comments.

OPERATOR: Yes, ma'am.

If you'd like to make a comment, please press star then the number one.

And there are no public comments at this time.

CO-CHAIR NILES: Thank you. Joe.

MEMBER KARAN: I'm going to apologize for this statement ahead of time.

It's the patient's view. Okay? And me being the patient, I'm going to tell you how I just felt about the conversation about technology.

In a world where everybody else is investing in technology, if the place where I'm going to depend my life doesn't, that's scary to me. As a patient that is really scary. And the fact that a hospital can't justify the cost? Because I deal with that all day long with

patients that are dying because they can't get the money to stay alive. And the emergency room is where a lot of my people go, as in hospital visits. Transplant patients and dialysis patients have tons of visits to the hospital and the ER.

And I actually would not re-say that statement to anybody I work with myself, because the competence that they need for the medical care, if there are a number of patients, you know, has the education to follow that I think would be very scared by that comment.

And you also kind of made it sound like it was kind of set in stone, that maybe someday it will change. Well, my medical problems aren't someday, they're now. And I find the lack of technology or the softening of it or the pulling back from it as something that could really be dangerous.

CO-CHAIR CANTRILL: Just to put you a little bit at ease.

MEMBER KARAN: Please.

CO-CHAIR CANTRILL: There is a lot of technology that's been purchased in hospitals across the country. In fact, it's been accelerated, some would say inappropriately, by the meaningful use. Certain things were pushed out before they were ready. But I would say most hospitals are very, very far ahead of where air traffic control is in this country in terms of the currency of the technology.

MEMBER KARAN: And you thought this, with me flying out tonight, this was a good time to bring that up?

(Laughter.)

CO-CHAIR CANTRILL: Just trying to give you some context.

MEMBER KARAN: I'm going to be yelling your name if I go down, I'm telling you.

CO-CHAIR NILES: All right. Do we have any other comments about this?

(No response.)

CO-CHAIR NILES: Hearing none, let's go ahead. And I'm going to turn it over to Kyle

and we're going to move on to what are our next steps.

MS. COBB: Sure. Happy to.

Because I don't think anybody's going to hear this. Everybody's eyes are on the door.

So we -- here is a little path of where we are. And we've got through all the purple squares. And this is how I'm going to talk at this point. I think people are pretty tired. We have a few more things to do. And it's important, actually, to look at the sort of the upcoming dates.

We will be finalizing our draft report in less than a month, essentially a month. I think today's the 26th of April, so a month from today. But that means that we will be, in the meantime, taking all the information that we've learned so far, and even more so in the last two days, assembling it in a report for which we'll include the panel's recommendations and prioritization of measures, measure concepts, as well as this past conversation and all the sort

of anecdotal information we've picked up over the last few days.

To that end we will be, we've surveyed everybody in terms of available time for the next few weeks for our small group get-togethers where we will follow up with some additional directions in how to score measures and rank them. I'm not going to introduce any of that today. We had thought we might. But what I will tell you is that in the next few days everybody will receive from their breakout group leader a summary of the work that you've done, with instructions of what to think about next.

And then we will meet in our small groups on these TBD dates in the next few weeks and we will discuss the next step in terms of how we prioritize measures for the recommendations in the report.

And then we will have our final webinar on the -- or the next-to-last webinar on the 4th to do our prioritization exercise, all together.

So that was a lot of saying more to come. Go home. Thank you.

Marcia has one more thing to say.

DR. WILSON: One more pitch on this public comment in the report. We put out a draft -- this is NQF process -- we put out a draft report for public comment. It's out for a month. The date there is actually incorrect, it's one month.

If you have listservs and want to share this report, we would love to have you do that. Because the more people that can see it in terms of public comment, the better. We'd love to get the different, especially the different stakeholder perspectives.

So what happens when those public comments come back, staff will get all of them. They respond to all of them. Now, sometimes the response is "Thank you for your comment." Often. But if there are, sometimes comments lead to changes in the report. We get some great feedback.

Also, that final webinar on July the 12th, the post-comment call, literally that's when staff present what we learned in the comments, what we responded. We may have some themes that have bubbled up to share with you. We may have some specific comments where you -- where we've crafted a draft response and say, Expert panel, is this how you would like to respond to this comment?

So, I would encourage you to just keep those dates in mind. And when we push out this draft report, please feel free to share them broadly.

CO-CHAIR NILES: Jessica, do you have any comments that you'd like to end with?

MS. OLDTMAN: Sure.

CO-CHAIR CANTRILL: Since you're paying the freight.

MS. OLDTMAN: Well, I certainly am not.

But on behalf of everyone at ASPR and, you know, in particular Brendan and Gregg and I,

I want to thank everyone for coming. This was a really, really great panel. It's really exciting to see so many people at the table, really interested, really engaged.

I think all of you can attest for the fact this is really important work. And I'm really excited. And I know Brendan and Gregg are really excited that we are really pushing the needle forward. And we appreciate everything you have done and everything you will continue to do. And we look forward to the draft report. So thank you.

CO-CHAIR CANTRILL: Jim.

CO-CHAIR NILES: Jim.

MEMBER DUNFORD: Yes. I would like to thank NQF. I think this has been a really productive trip east from my point of view. I really enjoyed it. You guys are all -- everything is 100 percent. There's only one thing that I noticed, and it's on the last slide. This arrowhead should be up one.

DR. WILSON: We need quality metrics

for that.

CO-CHAIR NILES: I guess we'll have to start all over again.

Thank you all very much. We appreciate it. We'll be in touch soon. Thank you.

(Whereupon, at 1:25 p.m., the panel was adjourned.)

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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.

Neal R Gross

Court Reporter