NATIONAL QUALITY FORUM

Moderator: Transition of Care
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OPERATOR: This is Conference #: 99272740.

Operator: Welcome everyone. The webcast is about to begin. Please note today's call is being recorded. Please standby.

Stephen Cantrill: I'd like to welcome all to the National Quality Forum Emergency Department Quality of Transition of Care panel. This is webinar number 4 and we are going to be working on prioritization and other recommendations and review web meeting.

Kyle, do you want to take roll?

Kyle Cobb: Sure. OK. So we'll not do internal roll but the internal team is all here, and let's start. So, Steve?

Stephen Cantrill: I'm here.

Kyle Cobb: Cantrill. Janet Niles?

Janet Niles: I'm here.

Kyle Cobb: Billie Bell? Donna Carden?

Stephen Cantrill: Donna is out of the country.

Kyle Cobb: That's right. Lisa Deal? OK. And I know Jim Dunford is 3,000 or 30,000 feet above us. Tricia Elliott?

Tricia Elliott: Here.

Kyle Cobb: Nikki Hastings?

Nikki Hastings: Here.

Kyle Cobb: Hello, Joe Karan?

Joseph Karan: Here.

Kyle Cobb: Hello. Julie Massey? Aleesa Mobley?

Karin Rhodes: Karin Rhodes.

Kyle Cobb: Oh, hi Karin.

Karin Rhodes: Hi.

Kyle Cobb: Elif Oker? OK, Andrew Pearson?

Andrea Pearson: Here.

Kyle Cobb: Marc Price? OK. And I know we have Karin Rhodes. Kristin Rising?

Kristin Rising: Here.

Kyle Cobb: Brenda Schmitthenner, sorry. OK. Amy Starmer? Adam Swanson?

Adam Swanson: Here.

Kyle Cobb: Can everybody hear me OK?

Stephen Cantrill: Yes, I'm fine.

Female: Yes.

Kyle Cobb: Arjun Venkatesh?

Arjun Venkatesh: Here.

Kyle Cobb: Sam West?

Sam West: Here.

Kyle Cobb: Margaret Weston? Christine Wilhelm? And Stephanie Witwer?

Stephanie Witwer: Here.

Kyle Cobb: Hello. OK. So, we – just to say a nice sort of pausing point after the in-person meeting. We've done a lot of work and really I have to just thank everybody once again eternally for all of your thoughts and time during both the in-person and subsequently we've done series of meetings and we've got really wonderful rich feedback from everyone around the measure prioritization.

And just want to step back a little bit, and bring everybody up to speed in terms of where we are and what we're doing. This is our last webinar before the draft report goes up for a final – for a public comment. And the report will go out on Friday for public comments. So for the most part, the report is done for now and the report is built on everything from the environmental scan, our meetings, your feedback, the work we did during in-person, it's based on the framework, the measure prioritization, our exercises that we've done, and then finally, the recommendations that we got from you during the in-person meeting.

And they were really – while we had them sort of at the end of the in-person, they were sprinkled throughout the two days of discussion. So we have really scrubbed every component of input to put it into the report and try put it in a way that it's comprehensible and more so actionable and – and really provide something that is concise and focus in terms of recommendations for improving transitions of care into an add of the E.D.

That said, we are now going to look at the focus of today's meeting is to look at the results of our prioritization exercise for the measure and measure concept, and then to walk through the final recommendation. And I will hand it over to Steve and Janet for that part and have a real discussion around sort

of get your inputs on the final recommendations on – if you could put your phone on mute. Thanks. And then we will talk about what happens in terms of public comments and the subsequent revisions of the report.

So, I will get started with that and talk about the prioritization result. So, we had a combination of 30 measures and measure concept, and that was a result of the work that was done during the in-person meeting through the domain specific small group as well as the post in-person meeting.

Each of the domains chose a series of measures and concepts that were put into a SurveyMonkey and we had about two-thirds of the panel was able to respond, so thank you for that. And measures and concepts were rank on – in two areas, and they were important in feasibility and we had a one through five Likert scale.

We – an important to note that we – when we looked at the results, we didn't wait Importance or Feasibility, and I'll get to that next. But you can see in the slide that the Importance distribution was not – end up not so surprising. We, you know, for the most part these were hand-pick measures and concepts. So, I would hope that they would all be important. So that was more of a validation that we had picked the past one.

Feasibility distribution a bit broader mainly because I think we did – we've suggested some fairly aspirational and long-term concepts that, as well know, are not ready for prime time. So, that's …

Stephen Cantrill: Yes.

Kyle Cobb: That's good. Another confirmation that we were doing, you know, we were doing our homework and we saw the right one.

Next slide, please.

So, we then set an overall rank score which is the product of the average importance and feasibility scores. We did not, as I mentioned earlier, wait them. We decided that there were reasons for them both to have equal ways

but we did, however, think about feasibility as the pointer for implementation readiness.

We did not use the overall rank as guidance for – for guidance, for implementation. So, you know, again the rank distribution, you know, it has some sort of natural cut off that has a nice tail, it's a good curve. Other than that, I don't think there is much that I can say.

But the next slide, we see that for the implementation readiness, we ended up with a couple nice steps of, you know, on the tail to the left, we have some aspirational long term, measures and concepts. We have a really nice health group of measures in the middle that are mid-term, that are good to work for that can be thrown to measure developers and thought about. And I think that those are really – it's a solid set. And then there are about five or six sets are ready to go for today, so.

With that, let's – let me review what the themes are within those groupings of today, mid-term and long-term. So for the measures that can be implemented today for the most part were existing measures. We had a provider communication measure that I think that everybody felt was pretty good could certainly be improved on, but there's also some patient-centered communication in specific discharge plan. Pretty good, but again, I think we all agree that they could, you know, they could be built upon but somewhere to start.

We also – for implemented concept came up for implementable today but to have the community resource information to support transitions available in the E.D., OK. You know, high importance and high feasibility.

Mid-term. Lots of mid-term teams – but I – no – nothing new. But the idea of care coordination navigator services improved and as I mentioned earlier, to sort of builds on the measures of today. We go from having, you know, some type of information exchange to improve instructions, additional elements included in those communications. And then start looking at, you know, timeframes in terms of how that information is transmitted.

And then, finally, I think it's being done in some places and not, but really thinking about how the provider and patient experience informs whether it's the feedback loop or the learning systems of E.D. to make it – to improve the quality of the transition.

So those are the pipeline of today measures and, you know, the pie in the sky measures. I think we're in general based on, you know, at that systems access to may be real time data and things that we just don't have right now. So, reduction and duplicate testing, improved transitions for frequent E.D. users, and the bi-directional communication between clinic – clinical and community resources to certainly one that we saw a lot of and we heard a lot of challenges with in terms of how you actually facilitate the sharing of that information.

And then finally looking at ways that patients and providers can have interactively share care plans. And I think this is really where we aspire to go but it's going to take some time.

So that is – I'm going to just pause there for any questions. And I, you know, from the panel about reactions, does this makes sense, does this – or is there anything that looks out of line with our prioritization?

OK.

Stephen Cantrill: Any comments at all?

Kyle Cobb: Everybody buys it? Or you're just so sick of us and tired.

Stephen Cantrill: They're looking for their mute button.

Kyle Cobb: I know. Yes.

(Crosstalk)

Arjun Venkatesh: Arjun here. The one thing – I don't know that – I feel like it should be part of the recommendations or it's kind of getting glossed over here. And I'm saying this from a perspective where I've seen it be a challenging – a challenge right now as we've tried to actually develop some care transition measures for the

(AHIP) registry, has been that there is – there needs to be some – we have to build the infrastructure and we have to kind of promote either policy or incentives for there to be freer data exchange between hospitals in order for that to be available to and used by the E.D.

And so it's not – I don't think the E.D. is going to say just build the infrastructure or the HIT recommendations that we have on this last side to make this happen when ultimately what it – what means to happen. I think the biggest sticking point has been that there's not a tremendous amount of incentives and work around improving information transfer between hospitals and emergency care is unique and that while there are (yes), our free standing EDs and things like that, it is largely a hospital-based specialty.

And so the vast majority of emergency clinicians are going to use systems or have access to infrastructure at the behest of hospitals. And so I think there has to be some place where we kind of note that as a – either as a barrier or as a – as an opportunity. But I think that that's important to emphasize. That, you know, you can't do clinician level measures or look at a lot of these things without capabilities being in place and that those are really dependent upon hospitals being willing to participate in information exchange.

Male: Yes.

Karin Rhodes: Or – this is Karin. Or health systems if you're working in a system.

Male: Yes.

Arjun Venkatesh: Sure, yes.

(Jesse Pines): Yes, and I – and some of the, you know, a lot of that discussion is in the draft reporting actually that actually is one of our recommendations is that sort of one of the basis for even, you know, for facilitating transitions is interoperable health I.T. and that should be promoted as the basis for this. And that's why I think some of the measures were more aspirational but we – but that, you know, that theme is definitely in there.

Female: And I would also add that we received fabulous feedback from all of the survey respondents. So there were comments that we gathered on each of the measures and concepts which we then went and sort of analyzed and looked at. And there were some cross-cutting themes, which I love when things work out so well, but I have to say that the cross-cutting themes were essentially aligned with our recommendations.

So the – and as you mentioned, Arjun, the, you know, infrastructure health information payment models were all of the sort of the challenges or barriers that were highlighted in the comments around the measures.

And, you know, for those that are curious, that is all included in the spreadsheet that we sent out as part of the meeting and it is also on SharePoint. But there's – within the spreadsheet, you have the measure, the ranking, importance of feasibility overall, implementation readiness. And then there's three columns for general comments, challenges and opportunities.

(Aleesa Mobley): This is (Aleesa Mobley). I just wanted to comment in terms of the infrastructure just getting back to the physical environment of the emergency department. The new V.A. health system that was built in New Orleans after Katrina has a discharge unit. So that when patients are being discharge, whether it's from the emergency room or the actual hospital, all of those things where you need to connect to the community services and the social services are done right there. So that may be part of the future of the infrastructure of emergency room.

(Jesse Pines): And just to comment on that. So in our recommendations, you'll see – one of the things that we do recommend is or to look for, you know, best practices like that or that, you know, sort of promising models of sort of streamlining this process and then trying to potentially use quality measurement as a way to sort of get models like that out there but that's a great example.

Male: Yes.

Stephanie Witwer: This is Stephanie and I don't know if this is discussed in the longer paper and not it would be very hard to put it in a actual finding, but there's – underlying

all of this is, is sort of this concept around cultural change. So part of what we're really proposing is that the EDs are even perceived differently in the future. You know, they're not as a standalone sort of place where patients are assessed and treated and moved on. They become a larger system of care.

But I don't know how we make that distinction in the report but I think there's a lot of cultural changes that we're suggesting here that we may need to just call out in some way.

(Jesse Pines): Yes. And, you know, we do have some discussion of that and we do sort of mentioned the, you know, the model being the, you know, the case that Kaiser Permanente model that actually does sort of integrate their EDs into the fabric form a, you know, information and actual process perspective. But I think that's a great point and definitely sort of something in the future we look to.

Female: We look at the language.

Male: Yes.

Kyle Cobb: And I would also add that the framework speaks to (us).

Male: Yes.

Kyle Cobb: That the idea that we have a domain around engagement of the broader community and thinking about how's the – that interacts with E.D. is certainly a culture changer and model changer. And when we think about those linkages and infrastructure, it certainly speaks to cultural change.

OK. If there's – you know, and please, if there are other – received e-mails and comments, you can talk more about the formal commentaries. But if there's something that you think of that you like us to consider in the next – I don't know, couple hours, please e-mail us.

I'm going to hand it over to Stephen Cantrill now.

Female: Wait. Before you do, I think there was a comment from – I forget who call – who e-mailed about the importance of including sort of community based references.

Kyle Cobb: Yes.

(Crosstalk)

Kyle Cobb: Yes. That was from Jim and we actually – apologies. I had meant to e-mail the panel this morning about that. We do – you know, again, lost in translation. We have a specific paragraph about that within the report that specific to social determinant. And it is – it is exactly what Jim had asked for, it's there. And I need to literally go and cut and paste of that section of the report and send it to everybody. But thank you for reminding me.

Female: Right. But isn't some of that may be sitting into the aspiration pieces? Do we – is it in there?

Kyle Cobb: It does.

Female: I missed it.

Kyle Cobb: That's a good – so let's – I think that's a good question in terms of teeing up the recommendation. So, the measures are really straightforward. We've been able to analyzed them base on importance and feasibility and we've been able to think about them within our framework, and how some of these are, you know, short-term, mid-term and longer term goal.

The recommendation really encompass more of the cross-cutting themes that we – we just identified across the measures whether it be infrastructure or health I.T., new payment models, and changes – cultural changes. But we need to – that is the next part of the discussion.

And in my mind right now, I don't have answer for how we balance the recommendation in terms of the short, mid and long term. Some of these we all understand it to be, what it is, and their sort of inferred but for me, it may speak to having some sort of structure around short, mid and long term. So, I

would just sort of throw that out there as we start thinking about the recommendation.

All I'll hand it over to you, Steve, because …

Stephen Cantrill: OK. Thank you. Can we go to the next slide please?

So the recommendations really fall into four different groups. And we'll go through each one. The first one is EDs need to build infrastructure and linkages to support E.D. transitions that are patient centered.

So, next slide. Next slide. There we go.

So – no, back up. OK, there we go. So we have four here in the infrastructure and linkages. And you can see them investments in E.D.-based care managers, navigators, and social workers, and referrals to community health workers and health care coaches. E.D.-based system for patients, I think it's pretty simple really and I'd be surprise to places don't do that now, where a providers available to answer questions. Regular screening of patients who may be at high risk for poor E.D. transitions in care, with the focus on unmet social service needs, and then information on community resources, ensuring resources are available for patients.

Now, Kyle, I think your comment about trying to put a structure in about what can we do now like the phone number and what is maybe aspirational or maybe mid-term or longer, like the regular screening of patients as we talked about before. I think that would be helpful to the general public and certainly to emergency physicians that will be looking at this to try to give them a time scale, oh, I got them, I going to have to this tomorrow. Or no, no, there's a lot that has to be done before we're able to implement that. Do you see what I'm saying?

Kyle Cobb: Yes.

Stephen Cantrill: And any other comments on these four?

Stephanie Witwer: This is Stephanie. I would just make one comment. It feels like, the concentration on this E.D. link – E.D. transitions out of the E.D. Just wondering if we need to also make sure that it's strong in terms of transitions into the E.D. So I'm not feeling as strong of the language there, it feels like it's …

Stephen Cantrill: I don't know if that covered in the text. (Claude), do you know – is that mentioned in the text report?

(Jesse Pines): Let me go back there.

Stephen Cantrill: Because I think that's a very good point. And we talk about that excessively.

Kyle Cobb: Yes, what does really is missing and maybe that it is on the text and I'm talking solid because I'm trying to think about where exactly it is. But it is around the provider exchange and (Jesse), I'm going to.

(Jesse Pines): Yes, so that concept is, you know, definitely the four sort of areas of the recommendations are not completely mutually exclusive. But I think we hit on that in the second one where we talk about health information …

Kyle Cobb: Yes.

(Jesse Pines): … technology health back and facilitate transfers into the E.D. and out of the E.D. So I think we do hit on that.

Kyle Cobb: So, yes. So then the first recommendation around infrastructure and linkages are really outside. And is there, you know – let's move on to and we can come back to this. If we don't …

(Jesse Pines): Yes.

Kyle Cobb: I can see just sort of semantics of infrastructure not including that provider communication.

(Jesse Pines): All right.

Kyle Cobb: And we talked about this earlier about even E.D. to .E.D.

Stephanie Witwer: And provider being kind of a broad term. I mean, (I put) our triage process in here in Rochester. And there is reach information of the triage nurses sending to the emergency department that I suspect is frequently not read.

Stephen Cantrill: Any other comments about these four recommendations?

(Jesse Pines): And just to look in particular in to be – if people have the full recommendation that really sort to hits on the, you know, specific elements that would be transferred between, you know, toward transfers in and transfers out.

But then I think it's a good point that we may want to make, you know, since we do have this the total of this is around sort of infrastructure and linkages we could make a board for the recommendation and the first one that would sort to tie in to this one.

Kyle Cobb: OK.

Karin Rhodes: One – this is Karin. One other comment on that is that at least in the text there should be some real explicit information that – because were 24/7, these investments, these care managers, navigators, whatever need to – we need to have access to them no matter what shift we're working or when the patient comes in, or there needs to be a strategy to link them after hours kind of things. So that could be in the text but if so fundamental to the nature of our practice that we just don't want 9 to 5 social workers and care managers.

(Jesse Pines): Right.

Kyle Cobb: Yes. And don't want it to be implied.

Male: Yes.

Arjun Venkatesh: I agree with Karin. The other thing that I – it's Arjun here, to add to that is that rather than calling it information on community resources, I think that, you know, we have to get pass the idea that the problem is just a lack of information. I think every E.D. has got little lists and their work around lists of resources. The problem is not, for example for us that I don't know where

the homeless shelters are or what housing options exist so that we have medical (inaudible). The problem is that I can not – we don't have any existing process in place to do that transition from the E.D. and so it requires you their hospitalization or I can't offer the service all day.

And so I wonder if we should be a little strong or anything, rather than information on community resources, it's really developing E.D. centric process for some of those community resources. Right now, like (cancer), they're not built to support the care delivery model of the E.D. and we could rethink of it that way.

Kristin Rising: This is Kristin. I kind of agree and this is for you, Arjun. I think actually having – I think you might be unique in the factor that you know where those various resources are. And I think for a lot of you even may really even be, you know, where can I go, where are the shelters, where other places that there are a lot that have that fundament limitation. I've even think of many of the residents in our program, they don't even know or actually a lot of these attendings, what the health centers in the city are. They don't know how they work. They don't have people get in to them.

So, I think, you know, potentially thinking that step on is kind of the next step for people. But I actually think that even some sort of fundamental information base is important to standardize across departments.

(Jesse Pines): Yes. And the example that we given, the recommendations in the text is the 211 system in San Diego that could actually did not an E.D. base systems, it's a community base system that has up to date list that EDs can use. Or that any provider can use. But, you know, I think in some communities where that doesn't exist, the E.D. at the very least have sort of an up to date list. And, you know, just sort of remembering back the, you know, the list of resources that which photocopied over and over again until it's, you know, sort of blurred out.

You know, I think that that model is sort of, you know, where stuff does go out of date. And it's not updated. It's something sort of that we should be

doing at baseline. But I think, you know, certainly, aspirationally, we would want those processes in place.

Kyle Cobb: And it sounds like there's a spectrum.

(Jesse Pines): Yes.

Kyle Cobb: Between sort of the information, all the way to as Arjun said, something that's E.D. centric process for it. But there's a need for the whole (sector).

(Jesse Pines): Yes.

Stephen Cantrill: OK. Shall we go on to the next recommendation, number two? This is health I.T. And there's seven, you see the first four here.

Health information exchanges should be viewed as a public good and supported by public funding or by payers. Sharing key information elements important to the E.D. transitions between clinical and non-clinical providers; support feedback about specific patients to promote a learning system. And then integration of information from multiple sources (E.G.) pharmacy data and prescription drug monitoring programs.

Any comments on those three? OK.

Karen Rhodes: So, I don't know if we did – this is Karin. Did we discuss the potential for sort of uniform cross-country medical record, right? Because that has come up with some of my qualitative work that patients are suggesting, you know, that that would be very helpful, like wherever you go, you could get your record. And that fits in the health information exchanges. But it's a little bit different; it sort of gives the patient some control.

And the main thing is like if you move from New York to California, you could still – the system could still access your record as opposed to right now, a lot of HIEs are very regional.

So, I don't know if that fits in here. But it is aspirational in terms of recommendation to think in terms of, you know, a uniform health care identifier that where you could access, you know, your records.

Stephen Cantrill: There is some work going on in that up in Oregon and Washington even across border transfer of patient centered information in terms of E.D. visits. It's a subset. So, there is some efforts in that area.

I mean that talk about the Holy Grail. I mean that's – I remember 40 years ago, talking with industry about trying to design a portable record. At that time, it was on (microfiche). But it's, you know, I think some times, the drive isn't there to do it.

Karin Rhodes: Well, it's not because economically all the EHRs are not incentivized to work together or have a, you know, be compatible. But I mean, I like – I really like that, you know, there's a public good. And I think some sort of move to uniform health record would actually give us a health system. And for the E.D. that would be like incredibly valuable.

(Jesse Pines): Yes. The, you know, just to comment on that. I was part of the discussion with a few months ago with some of the policy people at American College of Surgeons. And they had mentioned some, you know, groups including Google that are trying to sort of do this where the – all health information sort of lived in the cloud. And that organizations can access it about, you know, I don't expect this is going to happen on the – and probably in the near future. But this – this at least conceptually is under development.

And then to Karin's point, we do have a later recommendation about patient's being able to control their own health information which would, you know, could be facilitated by this, you know, information that lives in the cloud, yes.

Kyle Cobb: (Good button).

(Crosstalk)

(Jesse Pines): Yes.

Kyle Cobb: Put it in the cloud.

(Jesse Pines): Right.

Kyle Cobb: We can create. We can have rogue HIEs.

Karin Rhodes: So, you know, I think because that people are working on it and it's generally considered that this would move things forward. If we put it in as an aspirational recommendation for a unified health record and that this should be supported as a public good.

I think you could probably fit it in to this recommendation number two because sometimes, things just go leapfrog. And we are thinking forward about, you know, what we want to see in the future. And if Google is working on it, you know, I mean the change happens and fits and starts. And we don't want to like be asking for something that is already passé, you know.

Arjun Venkatesh: Yes. I would …

(Crosstalk)

Arjun Venkatesh: It's actually very real, in the sense that one of the people are work Harlan Krumholz has launched the program called Hugo which is essentially for those on you who know the finance side of apps if you heard of Mint.com where basically you access all your different accounts at different banks through the apps, it's like that for health care. And they've got, you know, 60, 70 health systems already where you – it's you as the patient are allowed to request your data and so now it's pulling together data from across different health systems and you make it immediately evolve with your clinician.

And so, I think it's real. And I think the way to maybe work into the section is really saying that, you know, the ideas supporting this kind of patient power health care information exchange is I think a way in which we will get it done faster and we will get this information to move between institutions quicker,

rather than the other approach which is trying to get EHR vendors to change products and hospitals and health systems to work together and develop kind of the more traditional exchange models.

And so I think it is definitely worth putting it in here.

Stephen Cantrill: I will agree with him.

Kyle Cobb: OK. HUGO, H-U-G-O.

Arjun Venkatesh: H-U-G-O P-H-R, I think Hugo Personal Health Record.

Kyle Cobb: Hugo PHR.

Stephen Cantrill: OK, next slide. These four more under recommendation number two in terms of HIT. Care team members to be contacted automatically when the patients arrives or departs the E.D., (census) and ADT alert system, shared decision making between providers and patients during transitions, considered patient privacy concerns when sharing the information between health care providers and community-based organizations, and then systems to improve patient understanding, e.g., evolution of symptoms.

Any comments on these four? I will say that the first one, I have a little reservations about – I talked with enough practitioners sometimes they don't want to know every time their patient shows up specially if it's a very minor visit because when you think about it that's a large stream of information. But I think – so we need to have some way to put a filter on that.

(Jesse Pines): Yes, and I think in the recommendations we just say that, you know, systems should be built to make this possible in sort of how that gets deploy, and to whom I mean obviously every patient you've seen even, you know, that mail when they have a new visit. But, you know, I think there be – there could be smart ways to use that, that providers would really want to know the information on the finance.

Kyle Cobb: You're not getting a work fatigue.

(Jesse Pines): Right.

Stephen Cantrill: And right, exactly that's the big thing we have to worry about.

Karin Rhodes: So, this is Karin. So we have like a clinical call center that will get the ADP, but there's only like it's a bundled payment patient, you know, comprehensive joint replacement or follow your heart patient, that will go directly to their care navigator.

So I think that if you could find way of saying what (Jesse) just said, and that's the think way. When appropriate they're contact it automatically.

Stephen Cantrill: Right.

Karin Rhodes: But it is tracked somewhere, yes the whole in this system.

Stephen Cantrill: Yes, yes, OK.

Aleesa Mobley: This is Aleesa Mobley. When I listened to the conversation it sounds like the physician is taking on awful lot of individual responsibility. I believe in emergency room just like our private practices, there should be more (a) team approach to this. If all the information is important because it's all of your patients then the practice has to have a way of filtering.

Its not that all those bits of information go directly to the physician, that person is busy. Just like in the emergency room that individual is busy. There are other people who are part of that emergency team. And we seem to be leaving them out of the conversation.

(Jesse Pines): So this would be sort of a centralized group and, you know, let's say the – you know, who's ever gathering the information about the click cohort of patients, let's say you manage by the patients at a medical home may get those alert as opposed to the patients actual physician.

Kyle Cobb: Yes, that's right.

Karin Rhodes: And I think – you know, and it's those care team and it's …

(Crosstalk)

(Jesse Pines): Yes.

Karin Rhodes: … a point well taken, I think its easy for a group of providers in the conversations to quickly assumed that that would their role.

(Crosstalk)

Karin Rhodes: And I think what we're hearing is that we have to be explicit about the various roles within the care team. And how this is sort of opened too.

Nikki Hastings: This is Nikki. And I think these are all important concepts about which particular member within the care team. I also think it's really important that we keep the concepts to patients' centeredness here too, because sometimes when a patients being actively treated for cancer, it's the oncologist and the oncology care team, that's really point person as opposed to primary care, people who have serious mental illness. Sometimes it's their mental health specialty care team.

So, ideally some way to insert the patient's full is about, who the critical providers on the other end of the transition are, would be helpful at least when we have a chance to sort of flesh this out in the narrative.

And I think this also goes back to the point that was made earlier about the importance of ED linkages with other providers. Because I share the same concern that's it – right started with and that we don't want – we want the alert, these alerts to mean something both the patients and providers. And the provider linkages piece, if that infrastructure is built then I think this becomes more of a process that has value rather than a check box kind of measure.

Stephen Cantrill: What I do like your idea of having the patient be involved in selecting who the alert would go out to.

Kristin Rising: This is Kristin, I have a comment on another of the bullet, is it OK to skip or is someone on the phone?

Stephen Cantrill: No, go ahead, go ahead.

Kristin Rising: I just wonder and I don't have the large – the larger documents in front of me, but the third bullet that consider patient privacy concern, seems kind of unnecessarily to be said in almost a little bit like strange to me just in the fact of like that should be an underlying that we're always doing. So, I'm just one – I'm not sure exactly where this came from and what specifically we're getting out with this. But I feel like that needs to be an underlying tenet of everything that we're doing, is that we're always considering that. I don't know what else we're putting in there but that's a little bit of unusual …

Janet Niles: Yes. This is …

Kristin Rising: … (bullet term).

Janet Niles: Yes, this is Janet. And I think I can speak a little bit to that and I think it's the wording because I kind of got hung up on the wording too. But basically what we were talking about in the in-person meeting was that there are some HIPAA restraints that keep people from sharing information with community based organization.

So it's not necessarily that we're considering the patient privacy concern, it's more that we have some regulatory and legal things that prevent that sharing, so maybe we should reword that.

Kristin Rising: Oh yes.

(Jesse Pines): The way – yes, the way that – yes, I think that's a – it's really good point. So one of the example that came up was this sort of comment consent form. So if that could be, you know, include community based organizations under, you know, under for information sharing. I think that would facilitate that, so we can – we can certainly make that clear in the recommendations.

(Crosstalk)

Kristin Rising: Develop processes or something to address patient privacy concerns with – or something like that.

(Crosstalk)

Nikki Hastings: I think along the same lines, identifying a draft patient privacy concerns that maybe a barrier to information sharing. So that we're proactively promoting the idea that information sharing and saying we've recognized this as a barrier and we need to work on it.

Janet Niles: Well, I'm not really sure and please correct me. But I'm not really sure that it's patient privacy concern, I think it's other people who have concerns about patient privacy. So I really rather see it send it around something along the, you know, what was just mentioned about some kind of all inclusive consent or addressing regulatory and legal barriers to sharing information as opposed to saying patient privacy concern.

(Crosstalk)

Kristin Rising: Yes. I hear that and I agree with that.

Karin Rhodes: And it's not a patients who is concerned, it's the – it's the greater – it's the greater community.

Kristin Rising: Agreed.

Kyle Cobb: And I think that people typically don't understand HIPAA, it's a big mystery. And so people don't stop when you even say HIPAA. So some type of way to have a consent that addresses that and this and whatever other associated regulatory concern.

(Jesse Pines): Yes. I like the language around sort of process to address barriers information sharing, I think that's the language …

Stephen Cantrill: That I think is a better characterization of it.

Kyle Cobb: Yes, process.

Stephen Cantrill: HIPAA is another great idea gone terribly wrong in its implementation, but then that's another story.

Any other comments about these four? Let's move on to the next slide, this is the recommendation number three new payments models, there are four recommendations here.

Global budgets, two budgets who reward hospital for coordinated care such as investment in E.D. Transitions, new reimbursement codes to support additional resources such as observation units providing more intensive care coordination services. Primary care providers, reimburse for coordination and efforts for follow-up not involve in an in-person visit and capitated payments to spur investments and improving E.D. transitions. And how much are they talking about hitting Medicare and Medicaid – any kind – any happy comments about these four? OK, any not happy comments?

Kristin Rising: Does our – our new reimbursement codes, is there anything that was talk about in terms of like thinking about between bullet two and three that kind of additional reimbursements for coordination effort conducted in the Emergency Department, that kind of being incorporated to the supporting additional resources?

(Jesse Pines): Yes. We do have a bullet on that and the sort of the text of the recommendations around sort of, you know, additional fee for service code, not just an observation but also in E.D. around care coordination or that, you know, repurposing just in codes or however you want to do that.

Kristin Rising: OK.

Nikki Hastings: Regarding point number three, I always say a lot of different type of provider provide coordination and follow up after an E.D. visit. And we might not want to be as specific as to say only primary care providers ought to be reimburse for that.

Stephen Cantrill: That's good.

Kristin Rising: Oncologist or …

(Crosstalk)

Stephen Cantrill: Yes. It may be a specialist providing …

Nikki Hastings: Exactly.

Stephen Cantrill: … coordination.

Nikki Hastings: That might be the most appropriate one.

Stephen Cantrill: Yes, yes.

Arjun Venkatesh: The other question I had, is what's the difference between number one and number four. I mean there are the terms capitated payment and global budget mean different things, but I think the point that we're trying to make with both of this is that a none few for service model whether there is some form payment across and any type of episode be that a capitated year or a global budget for a condition is going to reward investment in care coordination. So can those combined or there is some difference?

(Jesse Pines): Yes. But potentially, I mean sort of that the concept of global budgets hospitals versus capitated payment for a full population. You know, the – I think global budgets the hospitals certainly is more specific to the Emergency Department. Then capitated payment, but I agree it is sort of the same – it is the same concept sort, you know, payment for population – the population of patients, yes.

Female: They could be (enacted) or …

(Jesse Pines): Yes.

Female: … maybe physicians differently but they built on each other.

Kyle Cobb: Different examples of a similar idea.

Female: Yes.

(Jesse Pines): Yes.

Stephanie Witwer: This is Stephanie also thinking about is there any way to incentivize communities to fill in some of the care gaps that might be present in their community? Because they're just might be huge holes in some of the service available for ED transmissions in several communities.

Arjun Venkatesh: Yes. And I think we can make reference that the new accountable healthcare communities model, I know, you know, here we are one of the recipient, it's works is just getting started, but that's going to be making investments that are kind of, you know, multi sector health and non-health investment. That will down stream the infrastructure and resources that are going improve E.D. Care Transitions.

Stephanie Witwer: Right.

Arjun Venkatesh: And so …

Stephanie Witwer: So it seems like all of those would really help and supports the E.D. Transition, otherwise it sort of, you know, these recommendations tend to put the requirement on the hospital or the E.D. or the system I guess.

Aleesa Mobley: This is Aleesa Mobley, it sounds like you're going back to number three where we were talking about reimbursement coordination for all of those individuals who are not the physician. Well if that becomes a reimbursable code for the primary care physician for Transition of Care and that code is also connected to prescription for Transition of Care that links it to some community resource, then you have a motivation to get things moving.

Female: How did that go?

Stephen Cantrill: OK. Any other comments about new payment models? OK, lets' move on the fourth recommendation.

Karin Rhodes: This is Karin. I'm wondering if – I hate to say new reimbursement codes. If you are – I think globally just say – saying new reimbursement models that support additional E.D. services such as intensive care coordination services offered in the E.D. You know, just say different models as opposed to codes,

you know, I mean because it could be a lot more than just – because that still keeps in the fee for services fees.

So I would just say new models of, you know, payments – new payments models. OK.

Stephen Cantrill: My only problem with that is the new payment model is thrown around so much and I still don't know what it means.

Aleesa Mobley: Right.

Karin Rhodes: Exactly.

Aleesa Mobley: When you look at advanced care planning for palliative care, there actually is a reimbursement code for that. It is considered a new model, but they found a way to attach it – to attach that model to a form of reimbursement that's very specific. It's not a secondary encounter, it's a secondary code that goes with the encounter that you're having.

Female: I think you need the code to transition to wherever your going to go in terms of this model, they're a necessarily evil or not, depending on who you talk to.

Karin Rhodes: Then I would still say new reimbursement model including …

Female: Code.

Karin Rhodes: … code.

Female: Yes, including code, yes.

Karin Rhodes: OK. But, so because I realize – I totally agree it's too generalizable but to get two specific is problematic as well. So, you could say (E.D.) additional codes or other modalities, you know, whatever.

Stephen Cantrill: OK.

Nikki Hastings: This is a bit under new payment models necessarily, but I keep thinking about the comment that was made earlier about transitions into the E.D. And, you

know, there are a lot of places like nursing homes that are working really hard to figure out how to keep their patients out of the hospital.

And so, there – it seems like there could be some place here, where we could talk about EDs actively engaging with other efforts that are under way to improve care across to continue and reduce unnecessary transitions.

You know, those are sort of things that are already in play, so I'm not really sure this is the right place for it, but I would like to send a message that EDs have a very important place at the table with some conversations that are already going on around financial penalties for hospital admissions and transfers and other settings in the system including nursing homes.

(Jesse Pines): Yes, and there actually is a sort of a new model that's growing up in the Colorado, Denver area that actually does that, that's actually sort of led by E.D. physicians as part of servicing nursing home-based care for where they sort of keep – keep people in the nursing home as opposed to transferring them. So I think that maybe that can be sort of under future models, in the research agenda.

Kyle Cobb: Yes.

Karin Rhodes: So this is Karin. So, very similar lay we're using, you know, emergency medicine as providing online medical control for community paramedics who visit people in their home and, you know, we're treating them in their homes and leaving them at home communicating back with their treating provider for follow-up if it's appropriate.

So, I want to make sure that, you know, this is broad enough to cover those kind of models. And were the interact work that's being done around, we're doing Medicaid redesign with long term care facilities, very similar where the E.D. is being a resource.

So I really like the, you know, the previous comment as to keeping it really broad and maybe – but I – but a lot of times people only read the recommendations of this initiative. So, I think I still want to keep a little broader than just codes for additional E.D. type resources, at least frame it. So

it's, you know, it could support a variety of new deliberate models that the Emergency Department should be involved in.

(Jesse Pines): Yes and that's – and the group in Denver actually is working with local health insurers to create new codes around sort of in nursing home-based E.D. services. So that's a – so we can certainly extend that.

Karin Rhodes: Great.

Stephen Cantrill: OK. Recommendation number four, next slide please. Research agenda, agenda starting with Taxonomies to support improved E.D. Transitions, feeling both with provider-to-provider communication and provider-to-patient communication.

And then research to understand which patients are at highest risk for poor transition or poor outcomes, that really links back to one of the first ones we talked about in terms of the screening. And research to understand which interventions worked best to improve transitions and outcomes.

Any comments on either these entries?

Karin Rhodes: Is there a way to incorporate sort of the care team. So it's not just provider-to-provider but sort of provider-to-care team. Or, you know, something along that line. That would …

(Jesse Pines): To make them more general.

Karin Rhodes: … incorporate. Yes, makes it a little bit more general, I mean like as an additional bullet. Because we're talking about research agenda here, we can be, right, broad.

(Jesse Pines): So provider to community care team, (care agency).

Stephen Cantrill: Or it's care team to care team.

Kyle Cobb: Care team.

Female: Care team.

(Jesse Pines): Care team.

Kyle Cobb: Yes.

(Crosstalk)

(Jesse Pines): OK, good.

Karin Rhodes: Like it.

Stephen Cantrill: So any other comments about these two recommendations. Let's go on to the next slide please. We have one more under research. Identify and promulgate promising models for E.D. and community engagement including, community engagement with law enforcement, social services, housing and other resources, payer engagement and linkages between community and clinical providers and EDs.

I did chuckle when I read the first box, a lot of my patients are engaged with law enforcement.

Karin Rhodes: What about legal support, you know, I mean you have social service, but …

(Jesse Pines): Yes.

Karin Rhodes: … you know, thinking about the facts that some of our immigrant patients are afraid to come for healthcare, you know, that sort of thing. So, housing, food. You know, food insufficiency, you know, legal protection are not just the ones that are actually on their way to the jail.

Aleesa Mobley: This is Aleesa Mobley. I commend you for adding law enforcement, I was recently at a talked at Robert Wood Johnson where the police in the – I guess they left financially gratifying counties of New Jersey, were actually asking for assistance from healthcare providers. Because they are out there doing primary care in terms of mental health versus making an arrest, delivering babies, getting children out of bad situations of abuse and neglect. And they

were looking for assistance and how to keep themselves from just arresting people to getting people in its correct services.

Karin Rhodes: That's great comment, Aleesa. Maybe it's another bullet appropriate linkages to outpatient – inpatient and outpatient, mental health and substance abuse services. Or since it's a research agenda, identifying the best method of engaging patients with mental health and substance abuse services.

Nikki Hastings: With regard to bullet three, I would think about maybe explaining the wording or changing the phrase communality clinical providers. Obviously, community is incredibly important here and we have – we used the word community to refer to a lot of non-medical sources.

In resources in that context, it could be viewed as a little overly narrow and there's a lot of that outpatient clinical providers that we're really talking about our hospital base also. A little bit of semantics, but I'm just wondering if in bullet three for really talking about other clinical providers, would we want to (be there), talk about outpatient primary care specialty providers and do we want to call out specifically some of this other setting like we've talked about, and not just doctors office type setting, whether it's hospital based or a community practice, but also a nursing home.

(Jesse Pines): So for that language we would just say clinical provider (E.G.) and then sort of similar to what we did, we put the first one sort of give a list?

Aleesa Mobley: Or just add services, clinical providers' services and EDs.

Female: Yes.

Karin Rhodes: What about – what about …

Nikki Hastings: Well I think – might take on that bullet was that we were – we wanted to have a whole bullet for services, and then this is about medical type providers, am I reading that correctly?

Karin Rhodes: So what about linkages between clinical providers community base organizations and EDs?

(Crosstalk)

(Jesse Pines): (Debbie), the first bullet is sort of around the – around sort of the non-clinical piece, and then that's a third bullet, we wanted to capture mostly sort of the clinical linkages.

Female: Yes.

Nikki Hastings: So what about linkages between clinical provider or providers in outpatient clinics nursing homes and EDs? Or something along those lines.

Kyle Cobb: We can go with that.

(Jesse Pines): Yes, we …

Kyle Cobb: But I think it's, yes.

(Jesse Pines): … yes.

Kyle Cobb: We want to be broad enough that it's …

(Jesse Pines): Yes. Yes, we can maybe sort of give some examples and of what we mean by clinical providers, yes, (E.G.). Yes.

Karin Rhodes: And maybe realize we do home base primary care, so not just in nursing homes, you know, hospital at home type. So keep it broad enough there.

(Jesse Pines): OK.

Adam Swanson: This is Adam Swanson.

(Crosstalk)

Adam Swanson: I would also just echo the comment about mental health and substance abuse providers being parsed out, I think that connection is critical and although I feel like it could be covered in these three bullets that are laid out there right

now, I think being explicit about that is important given the context and the patient that's frequent to E.D.

Stephen Cantrill: That's an excellent point.

Janet Niles: Yes. I agree. This is Janet. And should we add something about looking at some type of research to identify the – and I don't even know how to phrase this, the ROI, the, you know, the cost effectiveness of doing these things because we're basing all of our recommendations on a fact that we think this is better for the patient, it's going to be more cost effective care, but we don't really address identifying if it's truly is cost effective care.

Stephen Cantrill: I think that would be excellent.

(Off-Mic)

Stephanie Witwer: This is Stephanie. Even research regarding effective clinical models for provision of E.D. services …

Stephen Cantrill: I've really like the used of the term ROI because I think that really gets to the heart of the matter and especially some of the folks that maybe or not as positive about it as we are would, I think, be very interested in that.

Karen Rhodes: So one way of framing that would be research that investigates the effectiveness and return on an investments of E.D. service – additional E.D. model services including both financial and health ROI.

Stephen Cantrill: Sounds good.

(Jesse Pines): How about just using the work cost effectiveness, which sort of puts it together?

Nikki Hastings: I would also throw in the term value, because I think ROI and definitely looks at it from the payer's perspective and that's really all you can incorporate in that type of analysis and that is unquestionably important. But I would argue that there is a way to incorporate the patient's perspective and a patient's centeredness to what a true value proposition is. And so that would allow

researchers to have a little bit more of a flexible model that's applied when you're examining value.

Kyle Cobb: Yes. I agree on what you're saying, but I also would like to say that it's not just payers that care about ROI. Having worked in a very large health care system, I can assure you that everything I wanted to do, every program I wanted to put in place, I had to have an ROI, the justification to do so. So the providers care too.

Nikki Hastings: Yes. I think the health system cares. That's the way I should have looked at it. So the health system, whether it's the people financing it or the people who are responsible for doing the best job they possibly can with limited resources which is kind of all of us that it matters. So, it didn't mean to overlay restrictive in terms of talking about who it matters to. But there is this broader concept of value that can incorporate some of that.

And maybe this is not something we pars out in the bullet point, but definitely a lot of research is trying to take that broader view of what value is. It's complex, but I think it allows us to incorporate a lot of the different elements of these things that we've been talking about.

Stephen Cantrill: I think we can …

Kyle Cobb: I agree.

Stephen Cantrill: If we use the word value though, I still think we should, you know, give specific examples of that because value, again, it's like pay model. This is a amorphous thing that really – but when you talk about ROI as an example of value or you talk about improved health care, then I think that really does galvanize you in terms of what are we talking about here. That would be my preference.

Karen Rhodes: So, value, you know, measures this research recommendation. So research that would look, you know, look at the value proposition of E.D. interventions for both patient's health systems and payers, including health ROI. I like putting – because it's not just improving the health system. It's really – we're trying to improve health.

Stephen Cantrill: Right. Well, I would …

(Crosstalk)

Stephen Cantrill: … health and financial ROI.

Karen Rhodes: Yes. Yes.

Nikki Hastings: Yes.

Karen Rhodes: I'm happy with.

Nikki Hastings: I think its one aspect that we want to understand. I just don't want it to seem like if ROI cannot be demonstrated throughout everything else we said before about these models because I think that's too restrictive of a way to look at it.

Stephen Cantrill: No, well that's what we have.

Nikki Hastings: And I know that's a reduction (inaudible) to summarize what I would say and we wouldn't do that. But I guess I'm saying I'm very supportive in hearing what Steve is saying and that it resonates to him as a specific thing that can be studied. And so as long as we frame it as an aspect and example of – for instance, the way the value can be looked at, I'm totally fine with it. The only caution is to suggest that's the only financial evaluation that we would support.

Stephen Cantrill: Well, that's why it gets important to include the health ROI as well as the component of that.

Kyle Cobb: I would – so this is Kyle. I would suggest that if we're going to be, you know, to go back just to the statement and the intent of it to look at these promising models of which for the most part having work on the bundle of payment initiative evaluation, they're hitting on all these points.

So I would go back to just look at evaluations of promising models where all of these differences are being considered under the value (report). So we're thinking about whether it's ROI or the patient's perspective and effectiveness.

I think we can word it to look at how their successful evaluations are seen in different ways, but not to get caught up too much on one or the other.

Marcia Wilson: Yes.

Kyle Cobb: That would be my …

Stephen Cantrill: That would be good.

Marcia Wilson: Yes, this Marcia. I would tend to agree because I think there's – now we've gone to value, ROI, cost effectiveness and all of the sudden we have opened up this ginormous …

Kyle Cobb: We can do that …

(Crosstalk)

Marcia Wilson: No. I will tell you, in other NQF work we have used Michael Porter's definition of value which is fairly widely accepted. But if we go where Kyle is going, could we add another bullet that would be research to explore the value of – and I'm not sure whether it's of the interventions themselves or the built E.D. infrastructure from different perspectives for example either return on investment, a health financial ROI, there's a health RIO, there's cost effectiveness and say that the bullet would be research to explore how value can be determined from building out E.D. infrastructure or interventions for transitions of care. But keep it at that level, is that anything …

Stephen Cantrill: That would be fine. Yes.

Kyle Cobb: And when you look at program effectiveness, you're looking at all of these components. It's not just the ROI that will make it effective.

Marcia Wilson: Right.

Kyle Cobb: I think that, you know, so when we're identifying, you know, as part of the research agenda to look at these promising models, you know, fingers crossed, some of that work has already been done.

Stephen Cantrill: Right.

Karen Rhodes: So I would change that from identify to develop, evaluate and (formulate) promising models because it's not the end all be all, we could develop but not just identify them.

(Jesse Pines): Develop, OK.

Kyle Cobb: Yes. OK. That works.

Stephen Cantrill: OK. Any other comments on the research agenda?

So let's open it up. Any other comments on general to all that we have covered so far? Do we – Operator, do we have public comment? Any …

Operator: Thank you. At this time, if you'd like to make a public comment, please press star one.

And there are no public comments at this time.

Stephen Cantrill: OK, thank you. Kyle, do you want to take over next steps?

Kyle Cobb: Yes, and I will then hand it to Kirsten.

(Crosstalk)

Kyle Cobb: … as our project manager.

Stephen Cantrill: That works.

Kristen Reed: Great. All right. So thank you all for your feedbacks and recommendations. What we'll do now is go back into the report and kind of put in your suggestions into those recommendations. And then we will be done with the draft report with very exciting. That will be posted publicly on Friday to begin our member and public commenting period which will go through June 26th.

And we do encourage you guys to make any comment, share it with your networks, really make sure that it gets out there so that we're getting all kinds of feedback.

Kyle Cobb: And we will – we can send an e-mail out to the panel when it goes up for public comment with the links to the page where …

Kristen Reed: Yes, we will definitely do that.

Stephen Cantrill: That would be great.

Kristen Reed: Yes. And then we will kind of compile any comments we received and present all of those to you on July 12th and really kind of go through about, you know, how do we want to respond to that, how do we want to incorporate them into the report, those kinds of things.

So, for now, you guys are free from us for at least a little while and we will look forward to talking to you again on July 12th. In the meantime, like I said, I'll send out the report and the link and instructions on how to comment and you can use that for yourself and to share it with all of your colleagues.

Stephen Cantrill: Good.

Kristen Reed: That's it …

(Crosstalk)

Kyle Cobb: But please comment.

Stephen Cantrill: All right. Any other comments today? I'd like to thank everyone for their ongoing participation. I think we've made a lot of progress and I look forward to the report.

(Jesse Pines): Great. Thanks, everyone.

Female: Thanks.

Female: Thank you. Bye-bye.

Male: Thanks.

Female: Thanks.

Female: Thank you.

Female: Thanks, everybody.

Female: Bye.

Female: Bye.

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

END