NATIONAL QUALITY FORUM

Moderator: Transition of Care
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Operator: This is Conference #99264768.

Welcome, everyone. The webcast is about to begin. Please note today's call is being recorded. Please stand by. You may begin.

Stephen Cantrill: This is Steve Cantrill. I'd like to welcome everyone to our post-comment Web meeting for the Emergency Department Quality of Transitions of Care Meeting. We've come a long way and, hopefully, will be able to wrap things up today.

I think we'd like to start with a roll call. Kirsten, do you want to do that?

Kirsten Reed: Sure. So, we have – Steve and Janet are with us. So, Billie Bell? Donna Carden?

Donna Carden: Here.

Kirsten Reed: Lisa Deal? Jim Dunford? Tricia Elliott? Nikki Hastings?

Nikki Hastings: Here.

Kirsten Reed: Joseph Karan?

Joseph Karan: Here.

Kirsten Reed: Julie Massey?

Julie Massey: Here.

Kirsten Reed: Aleesa Mobley? Elif Oker? Andrea Pearson? Marc Price? Karin Rhodes?

Karin Rhodes: Here.

Kirsten Reed: Kristin Rising?

Kristin Rising: Here.

Kirsten Reed: Brenda said she would not be joining us. Amy Starmer? Arjun Venkatesh? Sam West?

Sam West: Here.

Kirsten Reed: Margaret Weston?

Margaret Weston: Here.

Kirsten Reed: Christine Wilhelm? Stephanie Witwer?

Stephanie Witwer: Here.

Kirsten Reed: It sounds like someone's phone might be unmuted so we're getting some feedback. Can you make sure that your line is muted, please? Thanks.

All right. So, we are short (inaudible) on vacation without us.

Female: Kirsten …

Marc Price: Marc Price is here.

Kirsten Reed: Hi, Marc.

Donna Carden: Donna Carden is here.

Kirsten Reed: Great.

Stephen Cantrill: OK. Well, welcome, all. Our agenda is we're going to – a quick overview of the comments that we received. And then, we have some of the responses that

have been put together by the staff as proposals we're going to review. Then, we'll have time for questions and comments by the panel and, then, discuss our final feedback and recommendations and, then, review our next steps.

In terms of the comments received, we had 35 comments received from nine organizations. There were some major themes in terms of the responses. Many of the comments were very supportive of the draft, which was good. There were some domains and subdomain specific recommendations. There were some development and implementation challenges that were discussed. There were requests for clarification.

And then, there were some general recommendations. One was the role of EMS which, I guess, kind of mystified me in terms of reading all the responses. I don't think they got the kind of import that we felt that EMS played. But we're going to emphasize that. Some thought our approach is too broad.

There were some discussion about specific players. And I think our goal – it's my goal in terms of this – would not to talk about specific players but, rather, what functions are we talking about when we talk about transitions of care. Quite honestly, I don't care who does it as long as it gets done and gets done right. So – then there were some suggestions about including examples and graphics and innovative models as well. So – and I hope that you had time to review the comments and the proposed responses as well.

So, what we'd like to do now is just kind of go over some of the proposed responses for the – for the comments.

Why don't we go on to the next slide?

This is comment number two. And the comment really deals with where we've got demonstrated evidence in terms of the recommendation that a structure or process will improve patient outcomes, particularly given the potential requirements and cost of infrastructure, staffing and other resources required to implement some of the structural measure concepts. I think my thought about this is it – unfortunately, there is not a whole lot of evidence in

terms of many of these areas. So, we relied strictly on that. We wouldn't have much room to make any recommendations.

So, you can see the proposed response. "The report proposes one structural measure for future development and implementation. This concept is based on HIT infrastructure to provide patients access to health information via an online portal. The concept corresponds to the panel's recommendations for HIT enhancements to support quality transitions for which there is an evidence base. We agree that shared decision making concept is further strengthened with patient-report and have updated to – the concept to reflect this."

Any comments from the panel members concerning the appropriateness of this response or any suggestions to change? Or are you OK with the way it currently reads?

I'll take that as a yes.

Karin Rhodes: Well, so – this is Karin Rhodes.

Stephen Cantrill: Yes.

Karin Rhodes: Yes. So, that comes from the Federation of American Hospitals?

Stephen Cantrill: Yes.

Karin Rhodes: I think saying we recognize some of the current infrastructure challenges but anticipate that these will be overcome in, you know, short way because they are needed for a number of functionalities of the way health systems work and hospitals work and, then, sort of to go in to your comment, which your comment seems fine.

Stephen Cantrill: Do you think that's overly optimistic seeing that those challenges will be met?

Karin Rhodes: Well, I think they almost have to. We are in no man's land with a lot of poorly-functioning EHRs and a lot of things are being rapidly improved. And a lot of the quality metrics rely on you tracking these things. So, I wouldn't let them off the hook too much on this.

Stephen Cantrill: OK.

Karin Rhodes: So, I would just modify it a little bit that we recognize some of the current challenges but feel that this is very critical that we'd be able to capture and track, you know, communication between outpatient providers and the ED both in and out of the ED. And we're – you know, we recognize that may take a little while. But this is definitely going to be a quality issue. It is now and going forward.

Stephen Cantrill: OK. Kirsten, are you OK with that?

Kyle Cobb: Yes. This is Kyle. Yes. I absolutely agree with that. And I – this is Kyle, who originally – I did the first swing of the proposed response. And I think I picked up on the sensitivity with the federation as well and I'd like this addition to sort of produce some sort of recognition of the challenges. So – and it softens that a little bit. So …

Stephen Cantrill: OK.

Kyle Cobb: Thank you.

Stephen Cantrill: Good. OK. All right. Janet, do you want to take the next one?

Janet Niles: Sure. So, the next one we're going to address is comment three. Yes. Thank you. And it says that "It might be useful to clarify that the transition of care document is the patient care report somewhere in the document." And they also asked us to clarify the method as how the emergency department is receiving and EMS is sending the PCR from the EMS, whether it'd electronic, paper, verbal. And they wanted to know what standards, such as NEMSIS 3.4, are being used and what about measuring if the ED incorporates the ePCR data into the ED's EHR system.

For those of you who looked at the documents that were sent out last Friday, the response that's in the document is – it does not correspond. We did a little bit of revision to that. So, that response is incorrect. And what you have here is the proposed response, which is "We agree that standards are fundamental

to interoperability and data sharing and recommend the use of data elements that conform to EHR standards in the development of eMeasures." And so, we have a question. "Should this concept be updated to include patient care reports and whether or not the ED's EHR system incorporates the ePCR data?"

So, we are looking for your feedback. Any?

Karin Rhodes: So, I don't want to be the only person speaking up here. But I really like the comment or suggestion. And so, I would say yes. But I think that other people should weigh in as well. This is Karin.

Stephen Cantrill: Yes.

Margaret Weston: This is Margaret Weston. I agree that some clarification needs to be made. But my concern is, you know, the PCR is just part of the EMS system. There are going to be multiple documents that have to be standardized to be incorporated into the EHR. And do we really want to call out just the PCR report? I mean, there are reports that are coming from long-term care facilities, from other facilities, from transferring. I'm just worried about narrowing it too much.

Stephen Cantrill: This is Stephen Cantrill. That really doesn't bother me because when you look at it volume-wise, the EMS report, by far and away, is the most – the biggest volume that we have to deal with in terms with that. And also, reading through the comments, I think people were concerned that we didn't stress EMS enough. So, I think calling it our is reasonable. We can generalize it as well – EMS and other reports. But I would still be in favor of calling it out separately.

Kyle Cobb: So, we would then – this is Kyle. Just so that I understand, there is agreement to – in the measure concept to include a suggestion for standard reports such as PCR with the – with the understanding that there may be other types of standard reports that the measure would want to identify.

Stephen Cantrill: Right.

Kyle Cobb: OK.

Female: I think that's a better approach.

Stephen Cantrill: Yes.

Kyle Cobb: Yes. OK.

Stephen Cantrill: That would be good. Now, also, comment number four touched on this a little bit as well. And they were …

Female: Yes.

Stephen Cantrill: That comment talked about using data standards like, for EMS, the NEMSIS 3.4. I guess the question is how should we use that as an (EG) data standard such as NEMSIS 3.4 or should we call it out specifically? Any thoughts about that? Because, usually, NQF does not specific standards – data standards in terms of measure concepts. So, this is a little bit of a change.

Margaret Weston: How often do those standards change?

Stephen Cantrill: Well, that's why I would use an – I'm in favor of using the (EG), you know, because they can – who knows?

(Kyle Cobb): And I think there are other organizations that are setting this electronic exchange standard.

Stephen Cantrill: Yes.

(Kyle Cobb): Can we just reference the other bodies? It's really not up to us to define the standards but to reference to other defined standards. The standardization is the important part for our ability to measure.

Stephen Cantrill: Yes.

Female: I like that. So, we could do something along the – for example, NEMSIS with a focus on any data standard.

(Kyle Cobb): (Standardization). Yes.

Female: You know, it's …

(Kyle Cobb): I think that also gives you the – acknowledges the tremendous variation potentially that we're going to see. We're seeing a big push to getting electronic medical records together. But this information that's feeding into it, there's still – region-to-region, there's got to be variation into what people are using because of the long time to get to the standards we have with just the stuff we have in our four walls.

Female: For sure. And that – and that book probably hasn't even started – you know, we haven't even started writing it yet. So …

Karin Rhodes: Question. Do we want to incorporate anything about this data should be available at the time of the ED visit? Like timeliness is pretty critical for us and what they saw on the field. I don't know quite if this is where it goes in or – but it's not ….

Female: Is this the EMS data – should be …

Karin Rhodes: Correct.

Female: We have a concept.

Karin Rhodes: Well – or any transfer of data should be available at the time of the ED visit because the worst thing for us …

(Kyle Cobb): Yes.

Karin Rhodes: … is if like the patient has gone home and the next day we find out that they were hypotensive in the field or something we didn't pick up on. So, I think the timeliness would be pretty critical from any transfer documentation.

(Kyle Cobb): Yes.

(Kirsten Reed): So, Steve, I think that speaks to one of your comments where you would ask to just include in a timely manner to those various ones. So, is that sufficient?

Stephen Cantrill: Yes. You hate to set a hard stop. But the problem with just using "timely" is it's open to interpretation. But I agree with that absolutely completely.

Female: Yes.

Stephen Cantrill: Very often, what you find is the written report shows up days later and, in fact, it is at odds with the verbal report …

Female: Yes.

Stephen Cantrill: … that we used in terms of actually caring for the patient. And that's obviously a medical – legal huge problem as well. So …

Female: Yes.

Karin Rhodes: I am just – this is Karin again. I would be in favor of specifying that it's there at the time of the ED evaluation.

Female: Yes.

Stephen Cantrill: That's going to – the problem with that is if you're running a very busy system, there are going to be time when you have to go back in service to get another patient before you've completed the report. And I think to have – to be very rigid about that, you're going to set people up for failure. So, I think you've got to, you know, stress how important that is. But I would be – I would have problems with a hard stop there.

Karin Rhodes: Well, if you say "timely" and say "ideally at the time of" …

Stephen Cantrill: That would be fine.

Karin Rhodes: … "the ED evaluation."

Stephen Cantrill: Yes. That would be good.

Karin Rhodes: So, it's a little aspirational there. But in reality, if it – that information is not available and it varies from the verbal report, it's going to cause problems.

Stephen Cantrill: Yes.

Karin Rhodes: So, I think that …

Female: And I think, to that point – and this is in the – is in the measure concept when you actually get down to what the metric is. Maybe we're not targeting 100 percent because you recognize those other cases.

Stephen Cantrill: Yes. That would be – yes.

Female: That would be good.

Stephen Cantrill: Yes.

Female: OK.

Stephen Cantrill: OK. Now, I'll – any other comments about this?

Kyle Cobb: This is Kyle. Just that we have – we do have a measure for emergency transport communication. And that's within 60 minutes of transfer.

Stephen Cantrill: Yes.

Kyle Cobb: That's a – that's an established measure. We also have a couple of concepts that deal with this. And it then – so, the question I have for the panel specifically would be for the measure of the proportion of emergency or EMS transports where a transition of care document or a verbal report is provided to the ED at ED arrival, does that work? Does that meet the needs of the conversation? It's sort of the point that you brought up.

Stephen Cantrill: Yes.

Kyle Cobb: OK. Good. I mean, I assumed so. But we're not going to just …

Stephen Cantrill: Yes. I mean, I'll be honest. I have problems with the one hour for the established measure. I think that's bogus.

Kyle Cobb: OK.

Stephen Cantrill: For the same reason that saying that, OK, well, the EMS reports can be an hour late.

Kyle Cobb: Yes.

Stephen Cantrill: A lot can happen in an hour.

Kyle Cobb: Yes. OK.

Stephen Cantrill: And I think it should be ideally present with the patient no matter where the patient comes from, nursing home, wherever. And …

Kyle Cobb: Well, I'm going to add that to your – our commentary as a challenge for this measure.

Stephen Cantrill: OK.

Kyle Cobb: So …

Stephen Cantrill: That would be good. Yes.

Kyle Cobb: Yes. Information should be presented with the patient.

Stephen Cantrill: With the patient.

Kyle Cobb: Yes.

Stephen Cantrill: Regardless of where they come from.

Kyle Cobb: Yes.

Stephen Cantrill: OK.

Female: I like that.

Stephen Cantrill: Thank you. Any other comments?

OK. Moving on now to the next one. This is comment number nine. This is from the ENA. The comment was "The standardization of forms,

identification of key elements of information sharing and the electronic storage of information should not only be a recommendation but a requirement. The barriers mentioned can be overcome and monitored so that confidentiality is maintained during the sharing of information and coordination of the care is accomplished."

Our proposed response is "NQF is not in a position to make standardization requirements that support transitions of care. We, however, acknowledge and strongly recommend information exchange standardization as a means to support successful transitions of care."

Any comments about that response? OK. Everyone is happy with that?

Janet, do you want to take the next one?

Janet Niles: Sure. So, the next one also came from the Emergency Nurses Association. And this comment has to do with the EMS. And as we said, we got quite a few about those. This comment says "This doesn't address the EMS gateway into the system. In some areas, patients might be seen and treated in the field without subsequent transport and the information may be lost."

And so, our proposed response to that is "This project aims to identify ways to measure and improve patient transitions of care into and out of the ED and, ultimately, make the process more patient-centered. We recognize that these transitions – there are transitions that occur when emergency medical services, the police or the fire department respond to individuals who may or may not be transported to the ED. The environmental scan for this project engaged EMS stakeholders, and we agree that EMS plays a critical role in ED transitions of care. The report includes measure concepts specific to EMS information exchange with ED during a transition of care."

Any comments on that?

Kristin Rising: This is Kristin. I think that makes sense. I think it was just getting beyond the scope of what we were trying to address there.

Female: Indeed.

Female: Yes. I think so too.

Kyle Cobb: This is – this is Kyle. And I just – one comment that I have to make about sort of this comment and some other comments and Steve's earlier comment about EMS not having as great a presence in the report. I think it really does go back to defining, you know, the roles versus the functions and what we're trying to accomplish. So, of course, we can go back and have some clearer definitions of, you know, who we assume are all the people that are participating in this. But again, it really is just going back to getting the work done and not necessarily identifying or being too prescriptive about who those people are.

Female: Is there an appropriate venue for a communication of some of these for next steps or aspirational to be considered in the future because, certainly, it'd be nice to standardize some of the stuff on the EMS side too. But it's absolutely out of scope for this group. But …

Kyle Cobb: Actually that's an interesting idea. One way that we could – we could – and it's literally by just including a couple of extra words in the recommendation for HIT infrastructure. And I think that suggesting that as part of our HIT infrastructure enhancement to support these measures, one would certainly and absolutely be standardization of EMS.

Female: Yes.

Female: It's important – so, kind of foundational if you want to improve the information exchange in this kind of setting if we want to do any kind of automation. It's something to consider as another stakeholder.

Kyle Cobb: Agreed. And I think it would strengthen the report to include that in the recommendation. So, we can certainly fit it in.

Stephen Cantrill: That would be good.

Karin Rhodes: So this is Karin Rhodes. I just want to caution that we not be too prescriptive because EMS through community paramedicine is taking on roles of treating

patients and leaving it at home with online medical control not necessarily through emergency medicine, possibly through other, you know, critical care providers or online platforms with an EICU provider – that sort of thing.

So, we don't want to pretend that EMS is always and forever part of emergency medicine or should transfer people to the ED. We're trying in our system very hard to have them not transfer, to treat and leave people at home. So, just be careful – cautious about how we reword that. I don't disagree with anything that's been said, though.

Stephen Cantrill: Yes. I think it's – I think we're good. I don't – we are not being prescriptive in terms of every patient seen has to be transported. So, you know – and, obviously, we are – a lot of things are changing in pre-hospital care currently. I mean, some systems have done, you know, treatment releases for decades.

Female: Yes.

Stephen Cantrill: So, I think we're OK.

Karin Rhodes: And some of that treatment release may be with EM through online medical control that is consistent with our role as emergency providers. So, I think, maybe what about a statement in there that there's a lot of innovation. So, they wanted us to add innovative models. We care say there are EMS in the process of testing out new innovative models and telehealth opens up a lot of opportunities. So, we don't want to be prescriptive. But we do – you know, are in support of some standardized quality metric in the field and that's an opportunity for the future, you know, development – something like that.

Kyle Cobb: Yes. I think – absolutely. And I don't – and it maybe a sort of – something that we could add to the appendix where we have these innovative practices and we could have basically just an overview paragraph that points out that some of these innovative practices actually work to keep people out of the ED and we see that – see these new models as not necessarily improving transitions, but they are – they plug in to the overall sort of larger model and goal of where we believe quality to be.

Stephen Cantrill: So …

Female: Yes. I was just thinking that could also address the comment that we need to add innovative models.

Kyle Cobb: Yes.

Stephen Cantrill: Right. That would be good.

Female: Or discussion of that. Yes. That's great. (I like it).

Kyle Cobb: OK.

Stephen Cantrill: OK.

James Dunford: Hi. This is Jim Dunford. Can you guys hear me?

Stephen Cantrill: Yes.

James Dunford: Hi. This same issue of EMS came up recently here in California. The state California director had read the draft report, and he too actually expressed some concerns about the lack of emphasis of the importance of EMS. So, I think all the comments that everybody has made are very important to try to sort of at least lean in the direction to acknowledge all the amazing that is going on in states regarding EMS.

Now, one of the things that I thought that might – also is really important is the transition of care item that it is structural and that actually has to do with what we call (wall) times. I mean, the emergency department's essential functionality, a lot of you guys know, depends on the ability of ambulances to turn patients over. And with emergency department crowding, it's becoming really a nightmare across the country to have patients brought by ambulance to the emergency rooms only to sit for literally sometimes more than an hour or two before they can be moved to the setting of care in the emergency department. So, if there is ever a bad transition of care that needs to be focused upon, it seems (inaudible).

And in fact, in our state, we actually have a metric specifically to measure across hospitals what – how long does it take to get somebody from a gurney

into the sort of custody of the emergency department. So, it's not just communicating information, which I think the majority of our committee has spoken, but it's literally the transfer of the care itself needs to be done efficiently. And so, I would just make that strong case because in many communities around the country, emergency services are being hobbled by the fact that the emergency rooms are so overcrowded and there is a lack of standardization of the expectations to accept patients in the emergency department who come by EMS.

So, anyway, that's my one comment. Thank you.

Stephen Cantrill: Thanks, Jim, very much. I agree. That's a – you know, important issue.

OK. Now, comment number 13 was under perceived barriers. The comment – did not identify any barriers such as HIPAA, patient reluctance to share information across systems, information security, et cetera.

Our proposed response is "The panel considered barriers to information sharing and recognized HIPAA as a perceived barrier which needs to be addressed through our recommendations of creating HIT systems that facilitate secure data transfer."

Any comments about this response?

OK. Janet, do you want to take the next one?

Janet Niles: Yes. The next one is in response to comment number 19. And I think that this does tie back into what we just were talking about with answer – comment number 10 answer. But the comment was that this does not to address the most current cutting edge care models that are being deployed to better serve care – patients in need of urgent acute care and the concomitant follow up.

And our proposed response is that NQF has added an appendix to the report which includes a list of promising best practices. Also, you should note that this response is different, again, from the one that you received in the Word document on Friday on page 19. So, this is the – this is the current proposed

response. And again, there is a question here. Is anything missing on our best practices list that you guys did receive also on Friday? And I think, again, it does refer back to what we just were talking about with question number 10.

Donna Carden: This is Donna Carden. I just – I looked at the appendix and there are – there are some really nice novel, innovative processes there like the (JEDIYs) and the transitional care models.

I just wanted to add to what's already been discussed some of our recent findings that include that fact that if patients have time – and this is older chronically ill patients who present to the emergency department. If they have timely follow up with a primary care doctor that occurs from coaching in the ED, they are just as likely to return to the ED as people who don't have, you know, this coaching timely follow up. But if they do come back, they are less – significantly less likely to be admitted to the – to the hospital, which is an improved transition as far as, you know, quality of life and better maintenance of health.

So, I would just want to reiterate that one of the real innovative processes – it may not – it may not sound particularly novel – but, really, for high-risk patients, making sure that they have timely follow up with their own doctor is a – is a manageable process that can improve the transition of care for older chronically ill patients.

Stephen Cantrill: If they have a PCP. If they can get a PCP.

Donna Carden: Right.

Stephen Cantrill: That's the problem that we run into.

Nikki Hastings: Janet, this is Nikki Hastings. Can you just comment a little bit on the sort of organization principles that were used to put the appendix together? You know, I can see that some of these were hospital-based transitional care programs. We are looking for ones that are in practice or ones that have been tested with a certain level of research. Or in terms of thinking of anything missing, it would be helpful for me to think about what boxes we are looking to check for inclusion.

Kyle Cobb: Yes. Hi. This is Kyle.

Janet Niles: Kyle?

Kyle Cobb: Yes. I'm happy to answer that. You know, these are based on suggestions we've got – we've captured in conversations over the last six months with the panel. So, we are not – and they were also identified in our lit search. So, we – and our – we'd like to have them as programs that people – where there are learnings and they're innovative programs. And they're not necessarily ones that are – that have broad uptake.

So, I almost see this as the part of the report that these things are not measurable because not enough people are doing them and they are truly innovative and they sort of give people a glimpse of understanding where it can go. So, that's, you know – and that's probably scientific or rigorous. But we did feel that if there – our position is that we can't do an extensive one and claim to have scoured and, you know, put forth every single innovation program. You're never able to do that. But I thought we could really call the appendix something like, you know, innovations, you know, that have been observed or identified during the creation of this report.

Nikki Hastings: Got it. OK. Well, I might email a few to you …

Kyle Cobb: Great.

Nikki Hastings: … for consideration, if that's all right or a couple of models, particularly in the VA that are focused on the ED of primary care transition and communication tool …

Kyle Cobb: Yes.

Nikki Hastings: … that's used in L.A., for example.

Kyle Cobb: Perfect.

Nikki Hastings: So, I'll just …

Kyle Cobb: Yes.

Nikki Hastings: … send those via email.

Kyle Cobb: Perfect. And I know we do have a VA program listed.

Nikki Hastings: Yes.

Kyle Cobb: And I'm sure there is more. So, that's really terrific. Thank you.

Stephen Cantrill: That would be great. Thank you.

Karin Rhodes: So – this is Karin. So, I would – as part of DSRIP, the Medicaid redesign – incentive redesign that's going on in New York and, I think, a number of other states, they are incentivizing diversion from the ED to collocated primary care clinics that are right across the hall or right there as long as they ensure same-day visits.

Male: Yes.

Karin Rhodes: And I think that's definitely an innovation. So …

Kyle Cobb: Yes.

Karin Rhodes: … DSRIP initiatives are, you know, in California and New York. And I don't even know all the states that are doing them. But I think what you say, payment models that promote primary care follow up, I think I would say diversion to – I would separate that into both diversion for, you know, same-day primary care visits as well as follow up after the ED, you know, because those are two different things.

Stephen Cantrill: I would – I would worry about using the word "diversion." That is such a loaded term in pre-hospital care and it's always ...

Karin Rhodes: I know.

Stephen Cantrill: And it's always negative.

Karin Rhodes: Well, what about – but, it isn't just follow up. It's …

Stephen Cantrill: No. But you want ...

Karin Rhodes: … you know, you walk in, you go through some basic triage and you are sent one direction …

Stephen Cantrill: Right.

Karin Rhodes: … through one door where your – you can see a family medicine doc who could continue to see you.

Stephen Cantrill: We've been – we've been doing that for 40 years in Denver. I mean, it's ...

(Off-Mic)

Karin Rhodes: I know you have. Yes.

Stephen Cantrill: (Inaudible). But I wouldn't say diversion. I would say alternative destination.

Karin Rhodes: OK. I'm up for that.

Stephen Cantrill: OK. I just don't like …

Karin Rhodes: Totally.

Stephen Cantrill: Diversion just makes everyone crazy.

Kyle Cobb: Yes. OK.

Karin Rhodes: You're right. You're right. It's a hot button issue.

Kyle Cobb: Yes. OK. So, payment models that promote primary care follow up from an ED or alternative …

Stephen Cantrill: Initial (destination).

Karin Rhodes: (Inaudible) for acute care.

Stephen Cantrill: Yes.

Kyle Cobb: Or alternative – yes, sites for acute care.

Stephen Cantrill: Yes.

Kyle Cobb: OK.

Female: That's fine. And you can use this terrific examples of collocated primary care.

Kyle Cobb: OK.

Stephen Cantrill: Yes. That's good.

Karin Rhodes: And Denver's model.

Kyle Cobb: And Denver. OK.

Stephen Cantrill: Yes. An ambulance ride does not guarantee you being seen in the ED. Sorry.

Karin Rhodes: Right. Yes. There you go.

Stephen Cantrill: OK. The next one is comment number 22 dealing with impact of current policy. The comment is "How might we leverage the Medicare Access and CHIP Reauthorization, MACRA, to improve ED transitions in care? The 21st Century Cures Act drives toward better interoperability by, for example, setting up a provider directory to facilitate data exchange. It also helps to minimize information blocking among providers and facilities. How might we leverage the 21st Century Cures Act's provisions to enhance HIT to support high-quality ED transitions of care?"

And the question here is "Does the Panel agree with adding this information to the report? If so, how should this information be depicted?"

I am – go ahead. Comments?

Kyle Cobb: I'm happy to kick it off with a comment. This is Kyle. I think, you know, for MACRA, certainly, the MIPS and the other reporting – incentive reporting programs are certainly where this is – essentially what this report is for.

Stephen Cantrill: Yes.

Kyle Cobb: So, I think it's already supported and it sort of goes without saying and – but, you know, in terms of the interoperability part, I think we addressed it in our recommendations. We don't call out 21st Century Cures Act. But it's certainly is a phenomenal opportunity and sort of grant mechanism – money mechanism to support.

Female: I think that one caveat that I don't know that there's a good place for – with this related to the MACRA discussion. With the proposed rule, there is discussion about enabling ED providers' measures to be reflected by their hospital value-based purchasing. But this is a little different. So, it's still proposed. It's not in there for next year yet.

Kyle Cobb: Yes.

Female: So, the question is who are we measuring – who do we want to be measured on MACRA for really – you know, from – whose score gets affected?

Kyle Cobb: Yes.

Female: Is it an ED physician?

Kyle Cobb: Yes.

Female: Is it transferring – I mean, it's hard from an attribution perspective to say …

Kyle Cobb: Yes.

Female: … who are we measuring to go into that score. But if there's some way to try to bring that together to reduce the burden of reporting but to find a way for the measurement – I'm not sure if this is the best – if there's a good place within this around recommendations, particularly if we're moving away from scoring individual hospital-based providers differently than the hospital itself.

Marc Price: So this is Marc Price – as someone who participates with the CPC Plus program and also has to do MIPS, I can tell you that with our attribution, our empanelled patients – if you go to the ER, we're already affected by that. So,

we're already being affected by this. I would love to see some improvement that it's not just on the primary care.

Female: Agree.

Marc Price: How do you do that – how do you do that, I don't know. I don't have an answer to that. But …

Female: It's the not primary care and it's not just the ACO measures too because that's ...

(Off-Mic)

Marc Price: Right. It should be – right.

Female: But we need to connect the ED so they're part of this. Yes.

Marc Price: Right. Because everything comes back to primary care. Everything does. So, this should be – and for me, it'd be like, OK, put another gallon of water on my back when I'm already walking with a lake on there. So, this is just another drop in the bucket, so to speak. So, I agree we need to try to have some type of way to use this in everyone who's involved, not just to primary care.

Karin Rhodes: I think that's an excellent comment. I wouldn't call out specific legislation that might change. We don't know what's coming down the pike et cetera. But the comments are – you know, incorporate the concept here that it's a larger system-level issue that's being addressed, whether that's an ACO or a health system. And it reflects both the ED and the – you know, the episode of care type of approach in and out of the ED in some way – so, taking advantage of all opportunities to drive better operability and facilitate data exchange and that it needs to be measured on a system level – something like that.

Marc Price: I'll go along with something like that.

Karin Rhodes: Yes. It can't be an individual provider metric. You know, that's – we may even want to explicitly say that.

Female: On the other hand, if we're holding – trying to build partnerships between emergency hospital-based physicians and the hospital …

Karin Rhodes: Yes.

Female: … there may be some element of a shared responsibility around this, both the infrastructure that may be the hospital and the actual activity that you need the providers to participate. And there may be some measure to engage from that half of the exchange equation.

Karin Rhodes: I like the way you said that. Just say that maybe.

Stephen Cantrill: OK. Kyle, are you OK with that?

Kyle Cobb: OK. Yes. I have – I mean, in my note – and I think we can – just can go into one of the recommendation buckets. But it's something along the lines of our hope or, you know, the goal under MACRA is to move towards greater accountability. As such, our hope is that measurement – you know, we move toward measurement on a system level as, you know, for successful transitions of care not measured on an individual provider level.

Stephen Cantrill: Now, is there a way we can do that without calling out MACRA? My only feeling is as soon as you name legislation …

Kyle Cobb: Yes.

Stephen Cantrill: … you (get) what you've done.

Kyle Cobb: Yes.

Stephen Cantrill: Does that …

Kyle Cobb: Maybe we can – something about the environment. The incentives environment is moving towards …

Stephen Cantrill: Perfect. Yes.

Kyle Cobb: Yes.

Female: Quality incentives.

Stephen Cantrill: Yes.

Kyle Cobb: Quality incentives are moving towards shared accountability. As such, we – you know …

Stephen Cantrill: Perfect.

Kyle Cobb: We're encouraged that these types of models will better support transitions.

Stephen Cantrill: Yes.

Kyle Cobb: OK.

Janet Niles: This might – this might actually bleed into our next comment that we were going to review – it's number 26 – because that talks specifically about incentives.

Kyle Cobb: Yes.

Janet Niles: So, we may want to combine those answers.

Kyle Cobb: OK.

Stephen Cantrill: OK. Janet, do you want to take number 26?

Janet Niles: Well, as I was just saying, I think we can combine this. So, the comment was "In the recommendations section, it might be useful to provide suggestions for what levers/incentives/mechanisms, where appropriate, can be used to implement the recommendations."

So, the question to the panel is "Do you agree with adding this information to the report?" It sounds like we do. And so, what should we include? You

know – and this might be our opportunity to talk about pay for performance, value-based purchasing, whatever.

Karin Rhodes: So, I actually think this is slightly different than the prior comment because this really gets at what mechanisms whereas the other is the imperative for shared responsibility and reporting. And so, I think we can still keep them a little separate. Does that make sense?

Janet Niles: Yes. I think they could be separate. I think they could refer to each other because they are linked but not necessarily the same thing.

Karin Rhodes: Great.

Kyle Cobb: OK. And I think that in the – in the sort of the umbrella statement, it is that as we move towards shared accountability, these are the type of incentives that, you know, we absolutely (agree) or – no, I'm not actually tracking it as well. But the shared accountability model is the one that incentivizes quality transitions.

Janet Niles: Yes. (Inaudible).

Karin Rhodes: And I think that we want to say that there will be new mechanisms …

Janet Niles: Yes.

Karin Rhodes: … to encourage this. So, we're not limited to – so, we could say "such as but not limited to the following."

Janet Niles: Yes.

Kyle Cobb: Yes. We anticipate new ones.

Stephen Cantrill: (Good). OK.

Janet Niles: So, I think that was the last comment the last comment that we were going to go over. So …

Karin Rhodes: I think there's one more.

Janet Niles: Is there one more?

Stephen Cantrill: So, actually, one of the comments that people made was they would like to have some graphics or figures included in the – in the report. And this is a proposed figure to show kind of the interaction with the patient in the center and the different aspects of the patient's care in terms of the accessibility of services, shared decision-making and so on and so forth and, then, the folks that interact with those different components, the providers, the family and caregivers, and the outcomes and the community.

I had – I like this. I had one comment, though. We needed to disconnect the inner petals from the outer providers and families and caregivers because the way it looks now is it looks just the petals underneath these specific groups are the only ones that apply when, in fact, they apply – all apply to all the different groups. But any other comments or thoughts about the graphic?

Karin Rhodes: I like the graphic. I didn't think that it's just applied to – maybe you could have sort of like a – make – put that a little farther out.

Stephen Cantrill: There's a little …

Karin Rhodes: I didn't think it's – it didn't occur to me that it just applied to that.

Stephen Cantrill: Yes. In fact, Kyle already had some thoughts about how to disconnect the two.

Karin Rhodes: Yes.

Stephen Cantrill: It's just because I am a very concrete thinker. That's why.

Kyle Cobb: We have to – yes. We have to please everybody on this one. So, all different kinds of minds. But I think that having some – showing that they're sort of different – they're different circles and there's some movement, maybe some arrows could help with that.

Karin Rhodes: Yes. Maybe arrows between Providers, you know, Community, Outcomes like if the – it's sort of more of a circle of support.

Stephen Cantrill: Right.

Kyle Cobb: Yes.

Stephen Cantrill: Right.

Kyle Cobb: Yes.

Stephen Cantrill: And that's the direction we were going in.

Karin Rhodes: Yes.

Kyle Cobb: But that's helpful. And …

Karin Rhodes: So, this is a very nice one. It's very – I don't think it informs as much. I mean, you sort of want something that will inform your thinking about the function of this as well. I would keep this. I like it. But remember, I think you – repeatedly, we're putting up the little graphic of, I think – who was – who was this – maybe Kyle that went like A to B to C, you know, where B was the ED and …

Kyle Cobb: Yes.

Karin Rhodes: … you know, reconnected. I would like one like that too that – and how some of – I mean, you don't necessarily have to say what all the aspects of this are. But I sort of like the fact that, you know, the way communications goes. And …

Kyle Cobb: Yes. It's because this doesn't – this loses the – I mean, this address complexities on a different level. But I think it's the non – it's sort of the non-linear movement of a transition of care that – or potentially non-linear that it can do – and thinking about how there's these different segments, the A to B and B to C. We can …

Nikki Hastings: This is Nikki Hastings. Sort of along those lines, I think this is great and conveys many of the tough concepts that we've been talking about really well. I'm sort of missing the – any mention of emergency care or emergency anywhere on here. I'm just thinking if this gets disaggregated from the report,

it will hard to know what we're – what our core function was. You know, this could apply …

Kyle Cobb: Yes.

Nikki Hastings: … to so many different things.

Kyle Cobb: Yes.

Nikki Hastings: So, if we could convey our focus on emergency transitions within the figure, I think it might be more effective.

Kyle Cobb: Yes.

Nikki Hastings: From my standpoint in geriatrics – and this may be a very discipline-specific thing. But we tend to put the patient, the families and the carers all together in the center. It's just a little bit …

Kyle Cobb: Yes.

Nikki Hastings: It's just a perspective shift. And I'm not sure that's really …

Kyle Cobb: No.

Nikki Hastings: I'm not sure there is a right way or a wrong way. But I just don't think of families and caregivers on the same plane as providers …

Kyle Cobb: No. And it does ...

Nikki Hastings: … and then the community when you think about their relationship to the patient in all of these concepts.

Kyle Cobb: That's really helpful. And actually, if we go back to the first comment, I had pulled some – just a blurb from our work with the Person and Family-Centered Care Committee, which is also in my portfolio, as it turned out. But we – within our PFCC work here at NQF, we talk about – our guidance is that "patient" is really a term of art that includes caregiver, family members, parents and other involved in the team of care. And we see all of these roles

are critical in providing information and participating in the care process. So, as such, I think it is important to have all of those people assembled in the middle. And it could open up some room for ED-specific actors within this.

Karin Rhodes: So, you could almost sort of like have maybe some little octagonal leaves or one big leaf right behind that center one and that could sort of say "Emergency" or "Patient" …

Kyle Cobb: Yes.

Karin Rhodes: … "and their family in the ED," you know …

Kyle Cobb: Yes.

Karin Rhodes: … so that it situates that the patient is sitting in the ED and, then, we are – want to communicate with all these outside petals or, you know, connect with all the outside petals and the outermost, you know, providers – well, outcomes.

Kyle Cobb: Yes.

Stephanie Witwer: Yes. This is Stephanie Witwer. And I was also going to mention that to me, it seems like outcomes doesn't fit with the community and caregivers and providers. It just doesn't – I mean, it's different than those other three attributes or other three parts of the care circle.

Kyle Cobb: Yes. Well, we can take it back to the drawing board. This is – this is really helpful. And I can see – and, you know, that had also occurred to me when we put it together. And this really a straight translation of our domains and subdomains to a graphic. And you know – and it's always – I mean, I think it's always interesting to look at information formatted in different ways so you can sort of see what you're thinking and how these concepts relate to each other. But I absolutely agree that there – it needs to be grounded, you know, in respect to the ED and that, you know, outcomes maybe something – have a different place. But I – we need to think about that a little more because I don't – if we took outcomes out, then we'd be going right to a ring that was specific to the people that engage in care. And the outcomes really become

the things – the subdomains that are happening inside, whether it's safety or care coordination. And those would be the outcomes of quality transition. So, I think I have to (inaudible) (get that) captured. So, I think it's just a matter of going back and thinking about how we convey it.

Karin Rhodes: So, you could – rather than just have like one broad group of providers and community, you could have EMS …

Kyle Cobb: Yes.

Karin Rhodes: … long-term care facilities, home …

Kyle Cobb: Home health – yes.

Karin Rhodes: … you know, where you might put the families and caregivers, you know, community-based organizations …

Kyle Cobb: Yes.

Karin Rhodes: … (PBO) type …

Kyle Cobb: (PBO), HCB – yes.

Karin Rhodes: … you know – yes. Social needs, whatever.

Kyle Cobb: Yes.

Stephen Cantrill: My only concern when you start being very specific, you're going to leave somebody out and they are going to be offended.

Kyle Cobb: Yes.

Karin Rhodes: Yes.

Stephen Cantrill: They didn't – they didn't make it into the picture.

Kyle Cobb: Yes.

Stephen Cantrill: That would be – that's the one advantage of keeping it pretty general.

Karin Rhodes: A challenge.

Stephen Cantrill: Yes.

Kyle Cobb: Yes. The sins of omission are never good ones, as we've seen with the lack of EMS references in the report. And I think, truly we hadn't went – that really was just a – you know, it was an assumption that we had and …

Stephen Cantrill: That's the (inaudible), Kyle.

Kyle Cobb: Yes.

Stephen Cantrill: We're pretty good about talking about EMS.

OK. Any more discussion about the graphic?

Karin Rhodes: I wonder if you could incorporate into – like the outer circle – like if you take out all the – you know, providers, caregivers and call that emergency care services, you know, emergency care and show, you know, the ins and outs like pull that in to the A to B to C concept as well.

Kyle Cobb: I like that – emergency care services or emergency care providers.

Karin Rhodes: Yes.

Female: (Inaudible).

Kyle Cobb: And which is really – and, then, we have the sort of center being patient and their family. And then, all of these subdomains and things that are happening in the middle are really the outcome. So, we can somehow have ...

Female: (Inaudible).

Kyle Cobb: OK. Somebody's on the phone.

Stephen Cantrill: OK. Any other discussion about this?

OK. Thank you very much for your input on that, everybody.

OK. Moving on. Now, we're going to open it up to any comments or questions from the panel members. We're just all so happy that we're drawing this to a close.

Karin Rhodes: I think comments are just – that's been a really enlightening fun process. I would like to get, you know, the final link. What is our deadline or, you know, when is all this coming out or publicized?

Stephen Cantrill: Yes. Well, we will discuss that in next steps and we will get …

Karin Rhodes: Sorry.

Stephen Cantrill: We will – no. It's all right. But that will be done and Kyle will go over that.

Karin Rhodes: Are there references included in the final report et cetera?

Female: Yes.

Stephen Cantrill: Yes, there will be.

Karin Rhodes: That's a lot of work. Good for you, guys.

Stephen Cantrill: Yes. OK. Any other recommendations in terms of final feedback in terms of the final report?

OK. Operator, do we have any comments from the public?

Operator: At this time, if you would like to make a comment, please press star, then the number one on your telephone keypad. We'll pause for just a moment.

And there are no public comments at this time.

Stephen Cantrill: Thank you very much, operator. Kyle, do you want to go over the next steps?

Kyle Cobb: Vanessa is going to take this.

Stephen Cantrill: OK.

Vanessa Moy: OK. So, thank you. Thank you, everyone, for your feedback. And this will help us in writing and updating the draft report – I mean, the final report.

So, the next steps is that we're going to finalize the measurement framework report based upon your comments and feedback and from the public as well. And then – so, our last step will be to finalize that report which will go through copy editing. And the final report will be due on September 14.

Stephen Cantrill: And I assume that will be available on the Web as well.

Kyle Cobb: Yes. So, on the project page on the public NQF site – that's where that report will be. And we'll, of course – at this point, we're planning on getting it finished a little bit sooner than that. So, as soon as it is finalized, we will make sure to send you all your own personal emails with the link and the (access) to the full report so you guys can share it with whomever and look at all your hard work.

Vanessa Moy: Yes. And it will also be on the SharePoint as well on the – on the (panel) side.

Kyle Cobb: So, the – and just so that everybody knows, this is – it's due as a deliverable to CMS in mid-September. So, we see that as the final final line. But we do – it goes through pretty intensive copy editing and formatting here at NQF. So, it will – it seems like a long time away. It's actually not. And it has to go into publication queue. So …

Stephanie Witwer: This is Stephanie. I'm just curious. Does it go to any other regulatory groups besides CMS like Joint Commission or any of those other groups?

Kyle Cobb: Well, it goes to – well, ASPR was actually the initiator of this scope of work. So, it goes to ASPR and CMS. And in terms of it being picked up by Joint Commission or other regulatory bodies, I think that becomes part of, you know, the way that NQF works. We publish reports and we have press releases around them and there's a certain amount of exposure when we publish new material.

So, you know, certainly, Joint Commission would be part of that. And I don't know if (Trish) is on the line, can even speak to her experience with that in the

past. But anyway – so – but, you know, certainly, as panel members and participants in creating this report, I encourage you all to share it. And that's really how it works as well in terms of dissemination and spread.

Yes. So, I – go ahead.

Stephen Cantrill: Go ahead. I was just going to ask if there were any other questions or comments from the panel members.

Kyle Cobb: Well, it looks like …

(Janet Niles): Just to say that we enjoyed the opportunity for collaboration. Thank you.

Karin Rhodes: Ditto.

Stephen Cantrill: Well, I'd like to express my gratitude certainly to the NQF staff for doing a very nice job and to all the panel members for their willingness to give freely of their time and their expertise in terms of putting together this product. I think it's been, I think, a very interesting process. I think it really exceeded my expectations in terms of what I thought we'd be able to do, and I'm glad to be a part of this. And thank you all.

(Janet Niles): I will agree with all of what you said. And thank you, Steve, for being really the lead on this. I appreciate it very much.

Stephen Cantrill: Thank you.

Kyle Cobb: Well, this is Kyle. Steve and Janet, thank you so much for your leadership and for your expertise on this and to the rest of the panel. We can't – we can't do it without you. And this was just a really terrific group of experts and we very much enjoyed working with all of you and are just, you know, so grateful for everybody's time and thoughts on this project. It's really been tremendous. So, thank you.

Marc Price: Thank you very much. It's been a great opportunity and a great experience. This is Marc. Thank you.

Stephen Cantrill: Thanks, Marc.

Karin Rhodes: Yes. This is Karin Rhodes. And I want to really appreciate the – I think Jesse Pines and (Brendan Carr) as well and the people who really initiated this topic. It's so wonderful to see, you know, it moving forward in our field, these quality metrics that have been really nebulous. And I think it's going to help to improve our field. I'm very happy about it.

Female: That's wonderful.

Stephen Cantrill: OK. Well, thank you, all. We're going to give you about 50 minutes back to you – of your day. And again, thank you, all, for your participation.

Karin Rhodes: OK.

Female: Thank you.

Female: Thank you.

Female: Thank you.

Karin Rhodes: Bye-bye.

Stephen Cantrill: Bye-bye.

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

END