

NATIONAL QUALITY FORUM

IN-PERSON MEETING OF THE REGIONALIZED EMERGENCY MEDICAL CARE SERVICES STEERING COMMITTEE

May 23-24, 2011

DAY 2:

REMCS Members Present:; Andrew Roszak, JD, MPA, EMT-P (Co-Chair); Brendan Carr, MD, MA, MS; Arthur Cooper, MD, MS; John Fildes, MD; Howard Kirkwood, MS, JD, EMPT-P, EFO; John Kusske, MD; Thomas Loyacono, MPA, NREM T-P, CMO; Ronald Maier, MD; Ricardo Martinez, MD; Nick Nudell, BA, NREMT-P, CCEMT P; Jesse M. Pines, MD, MBA, MSCE; Kathy Rinnert, MD, MPH; Michael Sayre, MD; Gary Wingrove; Richard Zane, MD, FAAEM

NQF Staff Present: Eric Colchamiro, MPA; Lauren Richie; Sally E. Turbyville, MA, MS

HHS Staff Present: Tabinda Burney; Andrew Garrett, MD, MPH; Cynthia Hansen, PhD; Gregg Margolis, PhD, NREMT-P; Michael Rapp, MD, JD, FACEP; Tina Turgel, RN

DHS Staff Present: Joe Morris

UNC Staff Present: Charles Cairns, MD; Jeff Williams, MD

OPENING COMMENTS

Mr. Roszak reoriented the group and opened the floor to comments from the Committee:

- A suggestion was made to include “patient-centered processes” (such as waiting room times) under the guiding principles section of the report;
- Resource use was reiterated as an important factor;
- The pre-hospital realm, including timeliness, transport, and use of technology, should be considered as quality metrics;

Following the Committee’s comments, Ms. Turbyville gave a few thoughts from the first day:

- She noted the Committee’s interest in incorporating population health issues;
- an emphasis on leadership and the coordination of care; and
- adding an additional domain around access and capacity;

Dr. Cairns introduced updated definitions and revised domains, which he emphasized should be easy to understand and reflect the Committee’s thoughts expressed during the first day’s discussion.

DEFINITIONS:

Term	UNC Definition	Comments
Regionalization	The concept of an established network of patients that delivers specific care that is not universally available in the out-of-hospital setting or in some acute-care hospitals to a defined population of patients; regionalized care does not equal centralized care	--incorporates Dr. Kellermann’s suggestions for improvement --Committee members suggested making a distinction between patients and potential patients/a defined population
Regionalized Emergency Medical Care Services (focus on systems)	A deliberate planned system of both in and out-of-hospital resources that delivers care to a defined population of patients who have a condition for which rapid diagnosis and early intervention for acute injury or illness improves patient outcomes; while	--alludes to Dr. Carr’s emergency conditions language; Dr. Carr noted that they should be called “emergency care sensitive conditions”. --key concepts include non-emergency care, the effect of non-emergency care on emergency care, and to provide context for the system of care in which REMCS is provided;

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	<p>unscheduled episodic levels of care of varying acuity is provided in both the in-hospital and out-of-hospital setting of REMCS, the focus of this project is on following REMCS for time-threatening critical conditions.</p>	<p>--the importance of emphasizing systems within the definition --committee members suggested putting in language about “potentially life-threatening” conditions;</p>
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- Both “regionalization” and “regionalized emergency medical care services” will be defined;
 - “System of care” was incorporated into the definition of REMCS, but Committee members suggested that it be pulled out.
 - Committee members emphasized capturing how patients move throughout the episode of care model;
- A number of the medical-specific terms will be incorporated into the Framework report glossary;

DOMAINS

Following an initial review of definitions, the Committee moved into a discussion of domains:

- Phase 1 will have a loop to the newest phase;
- Phase 2 will focus on the out-of-hospital component;
- Phase 3 will be the in-hospital component of care;
- Phase 4 will focus on post-hospital care;

Based on SC input, a domain was added, which is entitled **“capability, capacity, and access” and is the first listed domain in the framework. This domain responds to the need** to understand the capabilities and resources of a system to provide emergency care. Capacity can change rapidly; so being able to measure a system’s ability is critical. He also added that regions can vary significantly in their access to care. Committee members emphasized that this domain spans the continuum of care and that access drives the other two terms – and should be placed first.

The third domain has been changed to include facility and specialty resources. The sixth domain remains the same, though a Committee suggestion to include “patient-oriented outcomes” was noted. Further, the whole system will be geared toward outcomes.

The second, fourth, and fifth domains remain the same.

Committee members also emphasized that, if at any point in the system of care, a patient dies—this is also a priority event. This event, along with situations where a patient moves through the entire model of care, should be considered as priority events and have measures to track and evaluate them.

Committee members also suggested that the feedback/process improvement efforts should be incorporated, that overly technical terms should be in the Framework’s glossary, and that the domains should not focus on hospital care.

WORKING GROUPS

Ms. Turbyville and Mr. Colchamiro then explained the working groups. The goal for each group was to provide a set of preliminary concepts and recommendations related to the various assigned topics. The key items from the small group discussions were to be shared and further discussed with among the full committee after the small group sessions. Recommendations from the working groups should inform the domains of the REMCS framework report.

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Domain	Working Group Comments
Detection, Identification, and Resource Utilization	<p>--Capture the first contact with help; --Episode of care begins when someone makes contact --phone rings at 911 dispatch center; --There is significant opportunity for things to happen prior to the 911 call; --Multiple interchanges of information around communication; --Resource utilization can be separated out here, but it's an aspect that belongs in the entire episode of care; --How can we predict and intervene before there is a need for emergency services? Disconnect between what is available and what's needed; --There is a lack of infrastructure;</p> <p><u>Committee Response:</u> --Need for advanced care planning, training and effective resource allocation; --Need to standardize structure and communication, so that it can be interchangeable; --Penetration of dispatch systems and electronic systems for detection – can these be quantified?</p>
Medical Care	<p>--Episode of care begins at symptom onset; --Focus on outcome measures as a method of validating the system; --Systems level metrics can be met, which are not condition specific; --Timeliness and adequate staffing measures are important to consider; --Disease specific conditions – but also response times, and being able to be seen in the ED; --Spreading the financial incentives to encourage care coordination and a shared accountability model, while aligning the degree of contribution to a particular outcome; --Consideration of standards around 911 and emergency radio systems should be included;</p> <p><u>Committee Response:</u> --Gather data and make it transparent in order to improve outcomes --Implement a clear oversight/system of governance structure to drive improvement --Establish multiple linked elements to produce effective medical care --Define the needs of the population, and fit the system around them</p>
Coordination of Care and Outcomes	<p>--Episode begins at any time when someone recognizes an incident; --Data (do we know to which hospitals the patient has been?), communications (online and offline medical direction for EMS providers), handoffs (inter-hospital transport, 911 call to EMS providers), clinical pathways (standards EMS drug boxes?), equipment, feedback are all important aspects to be considered; allow everyone in the system to receive outcomes data; --Group agreed with the emphasis on governance and shared accountability;</p> <p><u>Committee Response:</u> --The Committee did not provide any comments about this section</p>

COMMITTEE PRIORITIES FOR SECOND DRAFT

Mr. Roszak then opened the meeting for concluding comments from each Committee member present.

Suggestions included:

- Consider symptoms of care rather than diagnosis;
- Change the term “life-threatening” to “potentially life threatening”;
- Ensure that the episodes of care model is flexible and adaptive – and drives patient-focused, evidenced-based outcomes;

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- Emphasize importance of structural measures – so that we can come up with tiered processes of care;
- Incentivize coordination of care;
- Prioritize data standards – e.g. catalogue which hospitals will share patient information;
- Ensure framework report considers EMTALA statute;
- Highlight centers of excellence and best practices in the Framework.

NQF MEMBER AND PUBLIC COMMENT

Ms. Hansen encouraged the Committee to recognize surge capacity issues, in particular for catastrophic events. In addition, she encouraged the Committee to recognize psychiatric/behavioral health issues, and that healthcare is delivered through Indian American health organizations.

Mr. Margolis emphasized the importance of ED boarding, crowding, and diversion. He explained that the Framework could be used for standardization, but also to help develop metrics that would allow for evaluation and comparison, informing effective resource allocation. Overall, the Framework can be a key tool to drive system improvement and change; as it promotes measurement and public reporting.

Mr. Morris thanked the Committee for their work, and offered the support of his office.

Ken Nippert, of the National Volunteer Fire Council, joined the Committee via telephone and emphasized the importance of coordination with local fire chiefs and other fire professionals.

SUMMARY AND NEXT STEPS

Ms. Turbyville thanked the Committee for their participation, and reminded them of the project's timeline. The Committee will next meet, via conference call, on June 21 from 4:00 p.m. to 5:30 p.m. ET to review the second draft of the Framework report.

Mr. Roszak thanked the Committee for their participation and adjourned the meeting.