

NATIONAL QUALITY FORUM  
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REGIONALIZED EMERGENCY MEDICAL CARE  
SERVICES STEERING COMMITTEE

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MONDAY,  
MAY 23, 2011

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The Steering Committee met in the  
Monticello Room in the Marriott Crystal City,  
1999 Jefferson Davis Highway, Arlington,  
Virginia, at 9:00 a.m., Arthur Kellermann and  
Andrew R. Roszak, Co-Chairs, presiding.

PRESENT:

ARTHUR KELLERMANN, MD, Steering Committee Co-  
Chair, The RAND Corporation

ANDREW R. ROSZAK, JD, MPA, EMT-P, Steering  
Committee Co-Chair, Health Resources  
and Services Administration

BRENDAN CARR, MD, MA, MS, University of  
Pennsylvania School of Medicine

ARTHUR COOPER, MD, MS, Columbia School  
of Medicine

JOHN FILDES, MD, FACS, FCCM, UNLV Medical  
Center

KRISTI ANNE HENDERSON, DNP, NP-BC, FAEN,

University of Mississippi Medical Center  
HOWARD A. KIRKWOOD, JR., MS, JD, EMPT-P, EFO,  
National EMS Management Association

JOHN A. KUSSKE, MD, University of California-  
Irvine School of Medicine

THOMAS LOYACONO, MPA, NREM T-P, CMO, Chief EMS  
Operations Officer - City of Baton Rouge

and Parish of East Baton Rouge  
RONALD V. MAIER, MD, FACS, Harborview Medical  
Center

RICARDO MARTINEZ, MD, FACEP, Emory University  
School of Medicine

ALLEN McCULLOUGH, PhD, MS, MPA, MSN, Fayette  
County Public Safety

NICK G. NUDELL, BS, NREMT-P, FirstWatch  
Solutions, Inc.

JESSE M. PINES, MD, MBA, MSCE, The George  
Washington University Medical Center

KATHY J. RINNERT, MD, MPH, FACEP, University  
of Texas Southwestern Medical Center

MICHAEL R. SAYRE, MD, The Ohio State  
University

GARY WINGROVE, Mayo Clinic Medical Transport

JOSEPH WRIGHT, MD, MPH, FAAP, Children's  
National Medical Center

RICHARD ZANE, MD, FAAEM, Brigham and Women's  
Hospital

NQF STAFF:

HELEN BURSTIN, MD

ERIC COLCHAMIRO, MPA

LAURA RICHIE

SALLY TURBYVILLE, MA, MS

ALSO PRESENT:

TABINDA BURNEY, Office of the Assistant  
Secretary for Preparedness and Response

CHARLES CAIRNS, MD, FACEP, UNC-Chapel Hill

IAN CORBRIDGE, Health Resources and Services  
Administration

ANDREW GARRETT, Office of the Assistant  
Secretary for Preparedness and Response

KATE GOODRICH, Office of the Assistant  
Secretary for Planning and Evaluation

CYNTHIA HANSEN, Office of the Assistant  
Secretary for Preparedness and Response

MONICA LATHAM-DYE, Office of the Assistant  
Secretary for Preparedness and Response

GREGG MARGOLIS, Office of the Assistant

Secretary for Preparedness and Response

SUSAN McHENRY, NHTSA-Office of Emergency  
Medical Services

JOE MORRIS, DHS-Office of Health AffairsMIKE  
RAPP, Centers for Medicare and  
Medicaid Services

ADRIENNE ROBERTS, American Association  
of Neurological Surgeons

DAVID RYKKEN, Office of the Assistant  
Secretary for Preparedness and Response  
CYNTHIA SINGH, MS, American College of  
Emergency Physicians

NOAH SMITH, NHTSA-Office of Emergency  
Medical Services

TINA TURGEL, RN, Health Resources and  
Services Administration

JEFF WILLIAMS, MD, UNC-Chapel Hill

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

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

9:06 a.m.

CO-CHAIR KELLERMANN: I'm Art Kellermann. I am Co-Chair of this august group and this important process along with Andrew Roszak from HRSA and we want to welcome you to this event.

I'm going to start by passing things over to Helen for a moment, who is going to offer a few introductory comments, but we very much appreciate your coming here today. We very much appreciate your bringing your background, your experience, your disciplinary expertise and your knowledge of a complex and complementary literature as we go through the process today.

I'll have a few more remarks in a moment, but I wanted to hand things over to Helen and let her start and then Andrew and I will offer a couple of comments before we move into the agenda.

DR. BURSTIN: Great. Good

1 morning, everybody. Thanks for coming. I'm  
2 really pleased to see such a great crowd,  
3 including many of our federal colleagues, as  
4 well as our colleagues from UNC for a great  
5 kickoff Commission paper.

6 I think this will be a great  
7 discussion. I just wanted to briefly get just  
8 a couple of comments about frameworks, because  
9 we don't -- we do do frameworks at NQF. It's  
10 one of our endorsed standards.

11 We endorse frameworks, preferred  
12 practices and measures. And I want to set the  
13 context here. Basically, two kinds of  
14 frameworks that we tend to do. We tend to  
15 either do frameworks when it is a completely  
16 new area of measurement and we think it's  
17 useful to set up almost a tree of domains and  
18 sub-domains that people then begin to populate  
19 with the needed measures or practices, as they  
20 see fit.

21 A couple of examples of that. We  
22 recently did some work on cultural competency

1 and a framework for that, that clearly  
2 identified the key domains and sub-domains  
3 where we hope measures will emerge.

4 The second kind of framework, and  
5 I think this one sort of fits in both camps a  
6 bit is when there is a new area of  
7 measurement, where it's not so much an issue  
8 of identifying the key domains and sub-domains  
9 in the measurement gaps, but really thinking  
10 through a set of principles about how this  
11 measurement area may move forward.

12 So, for example, we did a  
13 measurement framework just a couple years back  
14 looking at an episode of care framework and  
15 how you would begin to align cost and quality  
16 together to get value.

17 And the thought is that there may  
18 be opportunities in this project to think both  
19 about measure gaps, but also there might be  
20 some interesting principles as we have had  
21 some of the discussions on the telephone  
22 about, for example, when can you take measures

1 that were developed for the healthcare system  
2 at the provider level and think about  
3 opportunities to have that flex up and down.

4 There are certain principles just  
5 as an example you might pick to select which  
6 kinds of measures would be most likely to be  
7 appropriate to flex up and down. So issues  
8 like that.

9 You've got a great team with you  
10 today. On our side, they have got -- they  
11 really know how to do this stuff, but also  
12 we're really pleased to have all this input  
13 from this group, our federal partners and I'll  
14 turn it back over to Art.

15 CO-CHAIR KELLERMANN: Thank you.  
16 A couple of quick housekeeping measures. You  
17 will notice we have these really cute  
18 microphones. They have a button. When you  
19 push the button, you get a little glowing red  
20 light, that tells you that you are active and  
21 you can speak.

22 The reason for this is not because



1 this room isn't small enough that our voices  
2 could carry, but so that they can capture this  
3 for posterity, because when you offer  
4 particularly pithy or compelling comment and  
5 we are going oh, I wish I had written that  
6 down, it will be on tape if you will push the  
7 little button.

8           It's equally important when you  
9 stop. So I may from time to time have to  
10 remind some of you over the course of the day  
11 to hit your little red button or unhit your  
12 little red button.

13           Second, I really do want to  
14 encourage everybody to be candid and  
15 forthcoming with your comments. The goal of  
16 this process is to make this document, make  
17 this the best possible start in a very  
18 important arena of work, which is to develop  
19 quality measures for regionalized assistance  
20 of emergency care.

21           We have a very solid beginning. I  
22 know we can make it even better. And all of

1 you around the table, I know, will have good  
2 thoughts, good ideas. This is not an occasion  
3 to be shy. Please, speak up. Please,  
4 contribute. This is a collective process and  
5 the goal is to have the best possible document  
6 that we can collectively put together. And so  
7 that's also very important.

8           The third request I would offer,  
9 unlike me, at the moment, please, be brief.  
10 When you offer comments, try to be succinct.  
11 Andy and I from time-to-time might ask you to,  
12 please, wrap up your comments, only because we  
13 want to have as much give and take around the  
14 table as possible.

15           If one of your colleagues has made  
16 a terribly compelling point and you know it is  
17 a great point and you really feel like if you  
18 could only have five minutes to say it again  
19 we would really get it, it's okay to say I  
20 agree with Dr. Maier and that will capture  
21 your sentiments perfectly.

22           But again, the goal is to be

1 dynamic, move forward, work through the  
2 information and come out of this with the best  
3 possible product. And again, I want to thank  
4 all of you for your time, your journeys for  
5 those of you who came from a long way and most  
6 importantly for your knowledge and your  
7 experience and your insights as we go through  
8 the day. Andrew?

9 CO-CHAIR ROSZAK: I agree with Dr.  
10 Kellermann. Thank you very much everyone for  
11 attending. This is a very important process.  
12 Thank you, particularly, to the NQF staff,  
13 Eric and Sally, and numerous others who have  
14 worked on this and the UNC who has started us  
15 off on the right track.

16 So I really appreciate everyone's  
17 time and effort. We do have a jam-packed  
18 agenda, as you have all noted. So I would  
19 like to go ahead and move into it and get  
20 started, if we could, please.

21 I believe we are going to do the  
22 disclosure of interests. And go ahead, Sally.

1 MS. TURBYVILLE: Okay. As all of  
2 you may recall, we did request that you  
3 complete a written disclosure of interest form  
4 some time ago. Today, we ask that you orally  
5 disclose any interest that you consider  
6 relevant to your participation on the  
7 Committee and that you believe your fellow  
8 Committee Members should be aware of.

9 We do not ask you to summarize  
10 your entire CV or everything that you may have  
11 revealed, but things that you may consider  
12 particularly relevant to the service on this  
13 Committee.

14 We suggest that you disclose  
15 grants that you have received in the last two  
16 years as well as consulting or speaking  
17 relationships that you may have within an  
18 organization.

19 I also want to remind you that you  
20 serve on this Committee as an individual, not  
21 as a representative of your employer or any  
22 other group with which you may be affiliated,

1 including the group that may have nominated  
2 you.

3 So what we are going to do is  
4 while you do your brief introductions, then,  
5 please, also follow that up with a disclosure  
6 of interest that you think is important and  
7 relevant to this Committee and that you want  
8 your Committee Members to be aware of.

9 So we can go ahead and perhaps  
10 just start with Andy and then move around the  
11 table.

12 CO-CHAIR ROSZAK: All right.  
13 Thank you. My name is Andrew Roszak. I guess  
14 I should disclose that I work at the United  
15 States Department of Health and Human Services  
16 for the Health Services and Resources  
17 Administration. I'm their Senior Policy  
18 Advisor in the Office of the Administrator for  
19 Special Health Affairs.

20 CO-CHAIR KELLERMANN: Art  
21 Kellermann. For the last year, I have been  
22 working for The RAND Corporation and currently

1 direct RAND Health. Current funding includes  
2 contracts with the Agency for Healthcare  
3 Research and Quality and HHS, ASPR, but RAND  
4 Health, obviously, does work with a number of  
5 federal, state and local agencies and  
6 foundations.

7 I have also done work in the past  
8 with CDC and NIH. I have no industry ties to  
9 speak of. I am co-patent holder on a use  
10 patent for progesterone and traumatic brain  
11 injury and that is at an experimental level in  
12 clinical trials and not available for  
13 marketing or for inappropriate promotion.

14 So you will not be hearing me  
15 advocate that during this meeting.

16 DR. MAIER: Well, I'm Ron Maier.  
17 I'm a General Surgeon, Trauma Surgeon, Chief  
18 of Surgery at Harborview Medical Center, which  
19 is the Level 1 Trauma Center for one-quarter  
20 of the land mass of America, as we like to  
21 say, including Alaska and part of Montana.  
22 It's easy.

1 I'm a Professor of Surgery at the  
2 University of Washington. I have been there  
3 my whole career, 30 plus years, which gives me  
4 the background and interest in today's topic.  
5 I have, a major component of my time is spent  
6 with the Glue Grant, which is a consortium  
7 grant from NIGMS looking at the genomic  
8 response to injury severity over time, working  
9 with Stanford, Harvard and the consortium in  
10 that effort.

11 I have been the recent Chair of  
12 the Board of Directors of the Trauma Center  
13 Association of America, which is a somewhat  
14 dissimilar source of collection of volunteer  
15 trauma centers who collaborate trying to put  
16 together information, primarily at the CEO  
17 level for financial stability and strength of  
18 the trauma centers in their various  
19 institutions. It should not be a conflict for  
20 this group.

21 And then, I guess, last I should  
22 throw in my son just graduated last year and

1 got an outrageously paying job at Covidien,  
2 but I don't think I'll be bringing up anything  
3 for Covidien while we are here today.

4 DR. WRIGHT: Joseph Wright. I am  
5 Senior Vice President at Children's National  
6 Medical Center here in the District of  
7 Columbia and I'm a Pediatric Emergency  
8 Physician by training. I've been there 20  
9 years and am a Professor of Pediatrics  
10 Emergency Medicine and Health Policy at the  
11 George Washington University Schools of  
12 Medicine and Public Health.

13 In terms of relationships that I  
14 need to disclose, I am the principal  
15 investigator at the Emergency Medical Services  
16 for Children National Resource Center and have  
17 been a continuously funded grantee in the EMSC  
18 Program for 15 years.

19 I also serve on the American  
20 Academy of Pediatrics Committee on Pediatric  
21 Emergency Medicine. And I am also a member of  
22 the National EMS Advisory Council. No



1 industry ties and I think that's it.

2 DR. CARR: Thanks very much. My  
3 name is Brendan Carr. I'm from the University  
4 of Pennsylvania. The disclosures that I think  
5 are pertinent are that I ran a conference for  
6 the Society for Academic Emergency Medicine a  
7 year ago about regionalized emergency care  
8 systems. I was Co-Chair of that conference  
9 and also co-PI of two Arthur T. grants, one  
10 from NINDS and one from AHRQ to fund that  
11 conference.

12 The conference was co-funded by  
13 ACEP-SAM and the Emergency Department Practice  
14 Management Association. In addition to that,  
15 we, along with my partner, Charlie Branas. At  
16 Penn, we hold two research grants, one from  
17 the Agency for Healthcare Research and Quality  
18 to study stroke systems of care and the other  
19 from the CDC to study trauma systems of care.  
20 But no disclosures of note from industry.

21 DR. FILDES: Good morning. My  
22 name is John Fildes. I'm an acute care

1 surgeon from Nevada. I'm a Professor of  
2 Surgery at the University, Vice Chairman,  
3 Program Director for General Surgical  
4 Training, Surgical Critical Care, Trauma Burns  
5 and Acute Care Surgery. And that's my day  
6 job.

7 I have had grants related to that  
8 that come from the Department of Defense in  
9 Fluid Warming in the Austere Environments and  
10 also Informatics Grants from Transportation  
11 and Injury.

12 I have a second job, which is that  
13 I'm the Medical Director of Trauma Programs  
14 for the American College of Surgeons. The  
15 American College of Surgeons Committee on  
16 Trauma holds grants from the CDC. And under  
17 grants from HRSA, I wrote the Open Source,  
18 Open Code National Trauma Data Bank and its  
19 Dictionary, which is a NEMESIS-compliant  
20 information system.

21 And I think that's enough for one  
22 day. Thank you.

1 MR. COOPER: Art Cooper. I'm a  
2 Pediatric General and Trauma Surgeon from New  
3 York City. Professor of Surgery at Columbia  
4 and a Director of Trauma in Pediatric Surgical  
5 Services at Harlem Hospital, one of our Level  
6 1 Trauma Centers in New York City.

7 I have been deeply involved with  
8 the Emergency Medical Services for Children  
9 Program also for 15, 20 years working  
10 primarily with my colleagues at New York  
11 University and Bellevue Hospital in terms of  
12 that effort.

13 Most recently, we have been  
14 working with the New York City Department of  
15 Health and Mental Hygiene on several disaster  
16 preparedness projects that are funded both by  
17 CDC and HRSA. I also have some small grants  
18 from the New York State Governor's Traffic  
19 Safety Committee for injury prevention  
20 purposes.

21 I, too, am a member of the  
22 National EMS Advisory Committee in addition to

1 several New York State advisory committees.  
2 And my primary professional involvement of  
3 late has been through the American College of  
4 Surgeons Committee on Trauma and the AMA  
5 National Disaster Life Support Executive  
6 Committee.

7 MR. KIRKWOOD: Good morning. I'm  
8 Skip Kirkwood. I'm the Chief of the Wake  
9 County EMS Division in Raleigh, North  
10 Carolina. I currently serve as President of  
11 the National EMS Management Association and  
12 I'm a senior consultant with Fitch and  
13 Associates in Kansas City. A paramedic,  
14 recovering attorney and no industry interest  
15 to disclose.

16 MR. WINGROVE: Good morning. I'm  
17 Gary Wingrove. I work for the Mayo Clinic's  
18 Ambulance Company. I'm a member of the  
19 National EMS Advisory Council. I did some  
20 work in NHTSA's Performance Measures Project  
21 and also convened a group that looked at some  
22 consensus measures and did some testing with

1 NEMSIS data.

2 I'm a recovering former State EMS  
3 Director and no industry interest to disclose.

4 DR. MARTINEZ: I'm Ricardo  
5 Martinez. I am currently faculty in Emergency  
6 Medicine over at Emory School of Medicine in  
7 emergency medicine. And I work clinically at  
8 Grady. The other roles I have is I'm on the  
9 ACEP Federal Government Affairs Committee. I  
10 was Co-Chair with Dr. Carr on the Consensus  
11 Conference about changing from Regionalization  
12 to Integrated Networks of Care.

13 I'm the senior physician for the  
14 National Football League for Super Bowl and  
15 yes, I can get tickets, so 23 years doing  
16 that. And until recently, was President of  
17 the East Division of the Schumacher Group that  
18 was an emergency medicine company.

19 DR. ZANE: Good morning. I'm Rich  
20 Zane. I'm the Vice Chair of Emergency  
21 Medicine at Brigham and Women's Hospital,  
22 Associate Professor at Harvard Medical School

1 and I'm the Medical Director for EMS and  
2 Preparedness for Partners Healthcare, which is  
3 a large network of hospitals in Boston.

4 I have funding from the DoD, AHRQ  
5 and HHS for preparedness work. I have no  
6 conflict of interest and I'm the Medical  
7 Director for the New England Patriots.

8 MS. HENDERSON: Hello. I'm Kristi  
9 Henderson from the University of Mississippi  
10 where I am the Chief Advanced Practice Officer  
11 there and have been a Nurse Practitioner in  
12 the Emergency Department there for many years.  
13 I am Assistant Professor at the School of  
14 Nursing there and am on the Health IT  
15 Committee as well as the Director of the  
16 statewide telemedicine program there.

17 I do have funding from FCC and  
18 USDA.

19 DR. RINNERT: Good morning. I'm  
20 Kathy Rinnert. I'm an Emergency Physician in  
21 Texas. I have an Associate Professorship in  
22 Emergency Medicine at the University of Texas

1 in Dallas. I have been involved in emergency  
2 care for almost 30 years now, although  
3 everyone says you look too young to have been  
4 doing it for that long.

5 I have been working with the  
6 Arkansas Department of Health in Missouri and  
7 Department of Health and Senior Services for  
8 a number of years and helping them develop  
9 their statewide trauma accreditation programs.  
10 And I have also been working with the American  
11 College of Surgeons Committee on Trauma for  
12 trauma consultations, which assist states in  
13 developing trauma systems in their  
14 jurisdictions.

15 I have no industry funding or  
16 grant funding to declare.

17 MR. NUDELL: Good morning. I'm  
18 Nick Nudell from Encinitas, California. And  
19 I work for FirstWatch Solutions. We do a lot  
20 of biosurveillance and 911 data surveillance,  
21 a lot of our customers are CDC-funded  
22 customers. We do a lot of CDC-funded work.

1 I have also previously served on a  
2 committee funded by CDC, the TIDE Committee  
3 where we worked on triage systems. And I'm a  
4 paramedic. And I have also done a lot of  
5 consulting work for states and systems who are  
6 funded by flex grants or local state grants.  
7 Otherwise, I have no declarations.

8 MR. McCULLOUGH: Hello. I'm Allen  
9 McCullough. I'm a Public Safety Director for  
10 Fayette County, which is a Metro County in and  
11 around Atlanta. In that capacity, I'm over  
12 the seven departments of public safety. I'm  
13 also an Emergency Nurse Practitioner. I work  
14 part-time at one of our urgent care centers  
15 and also one of our family free clinics.

16 I'm Chair of Education for the  
17 American Heart Association, also involved with  
18 EMS Section 4 International Association of  
19 Fire Chiefs. I have been involved with the  
20 National Registry and the Board of Directors.  
21 I have been for about seven years.

22 And I'm actively involved in the



1 EMS education teaching at the paramedic and  
2 critical care level for about 30 years and no  
3 conflict of interest.

4 DR. KUSSKE: Good morning. I'm  
5 John Kusske. I'm the Interim Chairman of  
6 Neurosurgery at the University of California-  
7 Irvine. My third time around as Chairman. I  
8 have no industry disclosures to make, at this  
9 time.

10 I have been involved in emergency  
11 care in California for about 30 years helping  
12 to set up the trauma systems in the state.  
13 And I have been involved with the National  
14 Neurosurgery for many years regarding EMTALA  
15 and emergency care.

16 I am presently the Chairman of the  
17 Board of the Institute of Medical Quality,  
18 which is a portion of the CMA, which deals  
19 with quality issues in the State of  
20 California. And I was the member of the  
21 EMTALA Tag and was Chairman of the On-Call  
22 Committee for physicians in the United States.

1 MR. LOYACONO: Good morning. I'm  
2 Tommy Loyacono. I am a paramedic, currently  
3 the Chief Operations Officer for the City of  
4 Baton Rouge, Louisiana. I have been actively  
5 involved in pre-hospital EMS for about 37  
6 years.

7 I currently sit on the Board of  
8 Directors of the National Registry of EMTs as  
9 their Vice Chair. I'm also a member of the  
10 Advisory Board of NEDARC and the EMSC National  
11 Resource Center in Washington.

12 I was a member of the sub-  
13 committee of the IOM Panel on the Future of  
14 Emergency Healthcare in the U.S. system and I  
15 have no grant funding to disclose, but have  
16 done many, many reviews, mostly in HRSA.

17 Thank you.

18 DR. SAYRE: I'm Michael Sayre and  
19 I'm an Emergency Physician at The Ohio State  
20 University, Columbus, Ohio. I did that for  
21 Chuck.

22 DR. CAIRNS: Thank you.

1 DR. SAYRE: And I currently have  
2 funding from Medtronic Foundation to help lead  
3 a project to improve cardiac arrest survival  
4 in five states by improving the systems of  
5 care in those locations.

6 I'm also currently the Chair for  
7 the American Heart Association Emergency  
8 Cardiovascular Care Committee, which produces  
9 training materials that are used in several  
10 countries and have received travel  
11 reimbursement from AHA for those activities.

12 DR. CAIRNS: Hi. My name is Chuck  
13 Cairns. I'm the Chair of the Department of  
14 Emergency Medicine at the University of North  
15 Carolina-Chapel Hill.

16 We have a number of grants that  
17 engage with this area of regionalization. So,  
18 first of all, it has been our pleasure to work  
19 with NQF on the development of the  
20 environmental scans and on the draft of this  
21 framework paper.

22 We have a group that is active in

1 EMS, particularly in regionalization quality  
2 and care issues, that has been funded  
3 currently by CDC and it is EMSC, The Robert  
4 Wood Johnson Foundation, the Duke Endowment,  
5 the Medtronic Foundation in conjunction with  
6 Michael's project, the American Heart  
7 Association Outcomes Project, as well as the  
8 State of North Carolina.

9 We also are engaged in  
10 biopreparedness research on a regional basis.  
11 That is funded by the North Carolina Public  
12 Health, the CDC and the Department of Homeland  
13 Security.

14 And then I am the co-director and  
15 principal investigator of the NIH U.S.  
16 Critical Illness Injury Trials Group along  
17 with Karen Cobb. And I serve on a number of  
18 data and review committees for the  
19 Resuscitation Outcome Consortium, the  
20 Pediatric Emergency Clinical Research Network.

21 And I have a number of  
22 organizational affiliations. I serve on the

1 American Heart Association Leadership  
2 Committee for the Council on Critical Care and  
3 Cardiopulmonary Resuscitation. I also am the  
4 past Chair and current member of the Research  
5 Committee of the American College of Emergency  
6 Physicians.

7 I also am the Co-Chair of the  
8 American College of Emergency Physicians  
9 Society for Academic Emergency Medicine  
10 Federal Task Force. And then finally, I serve  
11 on the Steering Organizing Committee of the  
12 U.S. Critical Illness Injury Trials Group.

13 MR. WILLIAMS: Good morning. My  
14 name is Jeff Williams. I'm an EMS Fellow and  
15 attending physician at UNC in the Department  
16 of Emergency Medicine funded by NQF for this  
17 project, the environmental scan and the draft  
18 framework that we have created.

19 I have a university grant, small  
20 university grant to study community cardiac  
21 arrest and integration of AEDs with public  
22 emergency systems. And I very soon will be

1 the Associate Medical Director for the North  
2 Carolina State Highway Patrol.

3 MS. RICHIE: Hi, my name is Laura  
4 Richie. I'm actually a Project Manager at  
5 NQF. I manage a couple of projects related to  
6 renal disease where I have just recently been  
7 asked to assist Sally and Eric in this  
8 project.

9 MR. COLCHAMIRO: Hi, Eric  
10 Colchamiro, NQF staff, and great to meet  
11 everyone today. If you have any questions  
12 over the next couple of days while you are  
13 here in D.C., feel free to contact me.

14 MS. TURBYVILLE: Are there any  
15 Steering Committee Members on the phone?  
16 Robin Shivley? Okay. Yes, it's open. Okay.  
17 We will --

18 DR. WRIGHT: Sally, I have one  
19 more that is important to disclose. I'm  
20 currently a senior investigator with funding  
21 from the Office of EMS at NHTSA to investigate  
22 proof of concept of evidence-based guideline

1 development for pre-hospital protocols. And  
2 that is a project that is ongoing and about  
3 halfway through and I think important to the  
4 process. Thanks.

5 MS. TURBYVILLE: Okay. And I'm  
6 Sally Turbyville at NQF. I'm the Senior  
7 Director on this project. So before we move  
8 on, thank you, all of you, for providing your  
9 introductions and oral disclosure.

10 I want to provide each of you now  
11 an opportunity, if you have questions of your  
12 colleagues regarding their disclosure, please,  
13 go ahead and do so now. Okay. Great.

14 So let's get started on the  
15 content of the meeting. I'm going to hand it  
16 over to Eric to kick us off and we will just  
17 keep moving through this agenda.

18 MR. COLCHAMIRO: Okay. And again,  
19 welcome. I am just going to touch over the  
20 next few minutes, and feel free to interrupt  
21 me if you have any questions, a little bit  
22 more about some of the work that has been done

1 and what is ahead for the Committee.

2                   So the Regionalized Emergency  
3 Medical Care Services Project began in  
4 November of 2010, funded under NQF's contract  
5 with the Department of Health and Human  
6 Services. As discussed previously, this  
7 project has two core components in this first  
8 phase:

9                   The environmental scan, fully  
10 developed or pipeline measures which was  
11 completed in February 2011, which is a  
12 resource document moving forward and then the  
13 Measurement Framework Report, a conceptual  
14 guide for measure development and what we are  
15 here today to really work on and to develop.

16                   And, as discussed, we have been  
17 working with the University of North Carolina  
18 as partners in this effort, but looking  
19 forward to your expert review of the document.

20                   The objectives of the framework  
21 report:

22                   To provide guidance to policy



1 makers, healthcare leaders and other key  
2 stakeholders toward a high performing  
3 healthcare system; to identify crucial gaps in  
4 measurement; and as a springboard for defining  
5 performance measurement; and to signal what  
6 type and where performance metrics are needed.

7 Really a key document in the  
8 potential second phase of this project where  
9 measures would be endorsed, this framework  
10 would really serve as a key point and a key  
11 guide for the community of measure developers  
12 as they seek to develop measures and submit  
13 them to NQF for potential endorsement.

14 And as the arrow at the bottom  
15 notes, NQF aims to establish that road map, so  
16 that when the measure endorsement happens down  
17 the road, that we will have a guide to where  
18 those critical gaps are.

19 The Steering Committee acts as a  
20 proxy for NQF within this project. It works  
21 with the staff and makes recommendations to  
22 the NQF membership for endorsement. So

1 following this meeting and subsequent  
2 conference calls, there will be a vote on a  
3 recommendation for endorsement.

4 As discussed during the  
5 orientation, there will be a review period  
6 where the framework goes out for comment from  
7 NQF Members and the public. And really, NQF  
8 gathers that consensus that is so important  
9 and that we all are going to be focusing on  
10 and the Committee will have an opportunity to  
11 respond to the comments compiled from NQF  
12 Members and the public.

13 And then moving forward as  
14 following a potential endorsement of the  
15 framework, the co-chairs would represent the  
16 Steering Committee when the CSAC meets to give  
17 final approval of the framework report.

18 A quick look at the time line. As  
19 mentioned previously, this project is going to  
20 be moving forward very quickly and we have  
21 noted the days previous, the orientation  
22 webinar, the first draft due, you can see the

1 in-person meeting and some tight turnarounds  
2 here, but all the more emphasis as to why this  
3 Committee's work is so essential and the  
4 comments today are so critical.

5 You can see the Member and public  
6 comment will happen in July and then as well,  
7 we will have additional conference calls to  
8 discuss the work as we move toward potential  
9 endorsement, followed by Member vote and then  
10 approval by NQF, CSAC and Board of Directors.

11 As far as relevant external  
12 efforts, as often discussed during the  
13 orientation call, there was the IOM and the  
14 important work done there that many of you on  
15 this Committee have seen and were involved  
16 with and the workshop from September of 2009  
17 and the subsequent report released in March  
18 2010.

19 The National Quality Strategy that  
20 NQF, through its National Priorities  
21 Partnership, was involved in putting together  
22 and the importance of better care and

1 improving the overall quality and making care  
2 patient-centered, reliable, accessible and  
3 safe.

4 And then some of the other  
5 efforts, we received suggestions about some of  
6 the other critical work for the Committee to  
7 consider and just a few of them are listed  
8 here, but the ACEP work on the State of  
9 Emergency Medicine, the Emergency Nurses  
10 Association Benchmarking Guide and then work  
11 done by folks in the international community,  
12 including Canada, as far as EMS planning,  
13 which can serve as kind of a comparative at  
14 looking how other countries have dealt with  
15 this work.

16 And as discussed during the  
17 orientation, a whole range of efforts to  
18 consider. These are just a few of them,  
19 including the work of many different specialty  
20 societies which were mentioned during the  
21 orientation call, but a few efforts to  
22 consider here.

1                   So that concludes my thoughts as  
2                   far as the overview and relevant external  
3                   work. And other comments from NQF staff to  
4                   report?

5                   MS. TURBYVILLE: Any questions  
6                   from the Committee Members about the project  
7                   or expectations from us and from you today and  
8                   through the course of the report writing? Oh,  
9                   yes, thank you.

10                   We did a disclosure of interests  
11                   and introductions and thank you for joining us  
12                   today. If you could, please, just provide any  
13                   relevant disclosures of interest that you  
14                   think your Committee Members or the public  
15                   should know about? And then also a brief  
16                   introduction, we would appreciate it.

17                   DR. PINES: Sure. I'm Jesse  
18                   Pines. I am currently at George Washington  
19                   University where I serve as the Director of  
20                   the Center for Healthcare Quality.

21                   And I think the only relevant  
22                   disclosure is currently I'm on the Advisory

1 Board for a company called The Doc Clock that  
2 measures ED waiting times.

3 CO-CHAIR KELLERMANN: Thanks  
4 again, everybody, for your introductions. I  
5 think as you hear us go around the room two  
6 themes emerge: One, this is an incredibly  
7 accomplished group with a broad array of  
8 backgrounds and interests. Second, all of you  
9 are terrible business people, because you  
10 haven't sold yourself to a lot of commercial  
11 interests, it's obvious to me.

12 Again, I want to express my hope  
13 that, as we go through this process, you will  
14 be very actively engaged, contribute your best  
15 ideas and really push this process, so that we  
16 can have the best possible product at the end  
17 of the day.

18 Are there any questions from that  
19 overview of the process that any of you have  
20 about what we are about today and how we are  
21 going to be going about our business that you  
22 would like to direct to the NQF staff? Dr.

1 Martinez?

2 DR. MARTINEZ: I echo your  
3 comments. We have a lot of smart people in  
4 here. And looking at what we are trying to  
5 do, my question is at what level are we trying  
6 to come up with measures? In other words, I  
7 can get real down nitty gritty. We're trying  
8 to just get high level measures for systems?  
9 What's the charge to the Committee? So we  
10 don't get bogged down at maybe the wrong  
11 level.

12 DR. BURSTIN: Just one correction.  
13 We are actually not going to get to measures  
14 today. This is really staying above that. It  
15 would really be identifying what are those key  
16 areas where you think measures are needed,  
17 rather than the actual measures themselves.

18 The hope would be that this report  
19 will then serve as an opportunity for measure  
20 developers to look towards and say this is  
21 what is needed.

22 DR. MARTINEZ: I appreciate that.

1 Thank you.

2 CO-CHAIR KELLERMANN: Other  
3 questions? Andrew?

4 CO-CHAIR ROSZAK: So we all have  
5 the agenda and the handout that kind of  
6 outlines what we are going to be going to be  
7 doing for the U.S. today. And then tomorrow,  
8 I'm sure all of you have received and  
9 hopefully have reviewed the UNC document that  
10 will serve kind of as a template or a  
11 strawman, if you will, as we start discussing  
12 some of these issues.

13 And I think it's safe to say,  
14 based on the conversations with the UNC staff  
15 and the NQF, that we are certainly not tied to  
16 this by any means. This is a starting point,  
17 not an ending point. And I don't think  
18 anyone's feelings are going to get hurt if you  
19 make suggestions or changes or deletions to  
20 this document.

21 So looking at the rest of the day  
22 today, we are going to go into a little bit of



1 detail and talk about some of the background  
2 work that has been done and hopefully set the  
3 stage to look at what measures are out there,  
4 what areas are already being measured and then  
5 also determine some of the gaps.

6 We are going to spend a little bit  
7 of time on some of the definitions and I know  
8 we have talked at great length about trying to  
9 define regionalization and we've done that for  
10 many years and I don't think that we are going  
11 to have a magic bullet and solve the  
12 regionalization definition problem today, but  
13 I do think that we are going to have to put  
14 forward at least a working definition, so that  
15 we can define what it is exactly we are  
16 talking about here.

17 So, you know, kind of in keeping  
18 with the comments about keeping this at kind  
19 of an elevated 30,000 foot level, I would  
20 implore you, please, not to get buried in the  
21 detail and we won't make a definition, but  
22 it's certainly not going to be something that

1 is the end all definition for regionalization.

2 We will have an opportunity for  
3 some public comment and I appreciate the folks  
4 who have joined us here in the room as well as  
5 those who are listening on the phone.

6 And tomorrow, we will be breaking  
7 into sub-groups to talk about the individual  
8 domains or buckets that we would like to  
9 examine to look at regionalized systems of  
10 care.

11 So that's kind of a brief  
12 overview. As the time line showed, this is  
13 kind of a tight time line. However, there are  
14 many opportunities built in to reevaluate what  
15 was done, to reevaluate what was done after  
16 that and to reevaluate again. So there will  
17 be opportunity by the Steering Committee, as  
18 well as the general public, to provide input  
19 and comment. So, please, don't think that,  
20 you know, after you walk out of here tomorrow,  
21 you will never hear from us again, because  
22 that's certainly not the case.

1           So that's kind of a little bit of  
2           an overview of what is going to happen today  
3           and tomorrow.

4           Art, have you got a few other  
5           things you would like to highlight?

6           CO-CHAIR KELLERMANN: Yes. Just  
7           it occurred to me that while we have a number  
8           of accomplished people at the table, we have  
9           an equally, if not more accomplished group,  
10          looking onto the table. And I wonder if the  
11          audience would indulge me for a moment and let  
12          each of you introduce yourselves as well.

13          You don't necessarily have -- I  
14          suppose actually, I could make you all parade  
15          up here to the microphone, but if you would be  
16          happy to -- do we have a traveling mike? I  
17          think that would be helpful, both for  
18          capturing the record and because we really  
19          have some extraordinarily accomplished people,  
20          both as individuals and representing  
21          organizations, and I would appreciate if the  
22          audience in attendance would introduce

1 themselves as well.

2 And at the end of that, we will go  
3 back to see if there is anyone in particular  
4 on the phone that would like also to introduce  
5 themselves that may be listening in. So if we  
6 could start on this side? Thank you.

7 MS. SINGH: Cynthia Singh. I'm  
8 the Director of Grant Development for the  
9 American College of Emergency Physicians.

10 MS. LATHAM-DYE: Monica Latham-  
11 Dye. I'm a Public Health Analyst with the --  
12 with ASPR.

13 MS. GOODRICH: Hi, I'm Kate  
14 Goodrich. I'm a Medical Officer at ASPE and  
15 I am the Project Officer for the NQF contract.

16 MS. HANSEN: Good morning. I'm  
17 Cynthia Hansen. I'm a Clinical Psychologist  
18 working in the Division of Preparedness  
19 Planning at the Office of the Assistant  
20 Secretary for Preparedness and Response.

21 MR. MORRIS: I'm Joe Morris,  
22 United States Public Health Service, assigned

1 to the Department of Homeland Security, Office  
2 of Health Affairs.

3 MR. SMITH: Good morning. I'm  
4 Noah Smith with the NHTSA-Office of Emergency  
5 Medical Services.

6 MS. McHENRY: Good morning. Susan  
7 McHenry, also with the NHTSA-Office of  
8 Emergency Medical Services.

9 MS. TURGEL: I'm Tina Turgel. I'm  
10 the Nurse Consultant for Emergency Medical  
11 Services for Children under HRSA.

12 MS. ROBERTS: Hi, Adrienne  
13 Roberts, the Senior Manager for Legislative  
14 Affairs with the American Association of  
15 Neurological Surgeons.

16 MR. MARGOLIS: Hi. My name is  
17 Gregg Margolis. I'm the Director of Health  
18 Systems and Health Policy for the Office of  
19 the Assistant Secretary for Preparedness and  
20 Response.

21 MR. CORBRIDGE: Good morning. Ian  
22 Corbridge. I work with my colleague, Andrew

1 Roszak, at HRSA.

2 DR. GARRETT: I'm behind the  
3 pillar. Good morning. I'm Andy Garrett. I'm  
4 the Deputy Chief Medical Officer for the  
5 National Disaster Medical System, also on  
6 detail as the Interim Director for the  
7 Emergency Care Coordination Center, an ER  
8 Doctor and an EMS and Disasterologist by  
9 training.

10 MR. RYKKEN: Good morning. I'm  
11 David Rykken and I'm the Senior Public Health  
12 Analyst at ASPR.

13 MS. BURNEY: Good morning. I'm  
14 Tabinda Burney. I work at the Emergency Care  
15 Coordination Center at the Office of the  
16 Assistant Secretary for Preparedness and  
17 Response.

18 MS. FRANKLIN: Hello, Angela  
19 Franklin, Director of Quality and Health IT at  
20 the American College of Emergency Physicians.

21 DR. RAPP: I'm Michael Rapp. I'm  
22 an Emergency Physician and a Director of the

1 Quality Measurement and Health Assessment  
2 Group at CMS.

3 CO-CHAIR KELLERMANN: Thank you  
4 very much. Are there any individuals  
5 listening in on the telephone that care to  
6 introduce themselves? Either no one is  
7 listening in or they are all being shy, but  
8 that's all right or they can't find their mute  
9 button, one of those possibilities.

10 Okay. Well, we are a bit ahead of  
11 schedule, but I want to give Dr. Cairns an  
12 opportunity to compose his thoughts, so we  
13 will take an uncharacteristically early break  
14 to give people a chance to stretch their legs  
15 and process their coffee and then we will  
16 reconvene.

17 Why don't we start a little --  
18 huh? Will that work? Okay. And we will plan  
19 -- we were going to reconvene at 10:30. I  
20 will propose that we actually reconvene at  
21 10:05, that will get us a little ahead of  
22 schedule and then we can beat on Dr. Cairns a

1 little more later.

2 So we will take a short break.

3 (Whereupon, at 9:48 a.m. the  
4 above-entitled matter went off the record and  
5 resumed at 10:09 a.m.)

6 CO-CHAIR KELLERMANN: Okay. Thank  
7 you all very much. Before we start with the  
8 presentation, a couple of other items we are  
9 going to cover quickly.

10 Eric asked me for the Committee  
11 Members to give a show of hands for those who  
12 would be interested in going to a nearby  
13 restaurant for dinner tonight, particularly  
14 for out-of-towners or in-towners who would  
15 like to do that. So if you are interested in  
16 joining the group for dinner tonight, please,  
17 raise your hand, so Eric can get a count.

18 Tell me when you are done  
19 counting, Eric. M&S Grill, a very nice  
20 seafood place around the corner. That's  
21 right. Eric, did you get your count? Okay.

22 Second, lest you all think that



1 I'm being bossy and Andrew is being retiring  
2 today, I have an unfortunate conflict with a  
3 major event on the west coast tomorrow, so I  
4 will not be here with you tomorrow. So while  
5 we are co-chairing, I'm getting to do a little  
6 bit more of the badgering today, because  
7 Andrew gets the full weight of his office  
8 tomorrow. So that's kind of how we have this  
9 division of labor.

10 And before we start with Chuck's  
11 overview, it occurred to us during the break  
12 that it would be really, really worthwhile to  
13 hear from our major federal partners to see if  
14 they have any opening or introductory comments  
15 that they would like to offer the group.

16 So purely arbitrarily, Sue, if you  
17 could start with NHTSA and then we will follow  
18 if anyone from Homeland Security would like to  
19 offer a few remarks followed by ASPR and then  
20 we will let CMS bat cleanup.

21 MS. McHENRY: Thank you very much.  
22 It's really -- is this on? Okay. It's really

1 good to see so many old friends and I look  
2 forward to making some new ones today. I am  
3 Susan McHenry with the Office of EMS at the  
4 National Highway Traffic Safety  
5 Administration.

6 And we are really glad to see this  
7 effort underway and we have a couple of  
8 initiatives that we have been working hard on  
9 that I think relate to the work that you will  
10 be doing.

11 One of the projects that I have  
12 the real joy of overseeing is our effort to  
13 develop our National Emergency Medical  
14 Services Information System, NEMSIS. And it  
15 is well along its path. We have now made it  
16 through three levels of approval with HL-7  
17 standard development organization, so we are  
18 kind of moving into the real health  
19 information technology arena and we are very  
20 excited about that.

21 We now have 30 states submitting  
22 to the national database. Everybody is

1 working hard on it. And our next version of  
2 NEMESIS, which is Version 3.0, is going to be  
3 much more robust relative to the various time-  
4 critical conditions and really enable us to  
5 measure performance in those areas.

6 And so I think that it will be a  
7 really good resource to help and will also be  
8 kind of a sequel to what happens in the  
9 hospital. So I think that we can really look  
10 at a whole system of care through some of  
11 those measures. So we are very excited about  
12 that.

13 And I'll be around, Noah Smith and  
14 I will both be around, all day today, so if  
15 any of you have any questions or anything, I  
16 would be glad to answer those. And I'm just  
17 going to leave it at that for now, because I  
18 know you have important work to be done.  
19 Thank you very much.

20 CO-CHAIR ROSZAK: Thank you,  
21 Susan. Joe Morris, do you have some Homeland  
22 Security remarks? Not to put you on the spot.

1 MR. MORRIS: I really don't know  
2 if I'm qualified. I have only been there  
3 since March, so I'm still in the steep  
4 learning curve of Rick Patrick and his  
5 tutelage. So I'll hold off right now.

6 CO-CHAIR ROSZAK: Okay. Very  
7 good. Dr. Margolis from ASPR?

8 MR. MARGOLIS: It's a pleasure to  
9 be here today and I'm looking forward to the  
10 conversation. I would like to, on behalf of  
11 ASPR, tell you how excited we are about this  
12 particular project and how important this is  
13 for us.

14 And I think that the work that has  
15 been done up until now has been outstanding  
16 and I would like to also encourage the group  
17 to make sure that we consider some of the  
18 broad systems issues that might help us get  
19 our head around regionalization of emergency  
20 care services, in particular, things like  
21 emergency department and EMS system capacity  
22 and capabilities and emergency preparedness

1 and resilience are really important issues for  
2 our office, as we are trying to build a  
3 healthcare system that is efficient and  
4 effective every day and also is capable of  
5 responding to disasters and public health  
6 emergencies.

7 So I would ask that you make sure  
8 that you think about those kinds of variables  
9 in addition to the very important patient care  
10 kind of individualized variables that are  
11 indicators of quality emergency care.

12 CO-CHAIR ROSZAK: Thank you. Dr.  
13 Garrett, would you like to make some remarks?

14 DR. GARRETT: I agree with Gregg's  
15 comments, that's very much what I would say as  
16 well. I think, you know, we're really  
17 excited. The implementation, as you know,  
18 it's just, you have a pillar for the emergency  
19 coordination center and whatever strategic  
20 plan moving forward acknowledging that the  
21 role that we've been playing is really doing  
22 great things in emergency care. So I would

1 like to make a statement, a plug at this  
2 point.

3 The strategic plan, which you will  
4 see, is out right now. We would love any  
5 comments from people who have had a chance to  
6 review it. I would be honored to have any of  
7 the thoughts from the folks around the table;  
8 we're at a neat turning point. I guess this  
9 is the important part. Thanks for inviting  
10 us.

11 CO-CHAIR ROSZAK: Thank you. Dr.  
12 Rapp?

13 CO-CHAIR KELLERMANN: CMS, if you  
14 could speak through a microphone, that would  
15 be helpful, so we can capture it. You can  
16 borrow one of the --

17 DR. RAPP: So thank you, Art. At  
18 CMS, we were very supportive of this project,  
19 too, and I would like to just give a couple of  
20 perspectives on it as we think about  
21 measurement.

22 So where we are right now at the

1 CMS level and we do a lot of quality  
2 measurement and those quality measures are  
3 incorporated into a variety of programs. We  
4 started with just quality improvement and then  
5 we moved to pay for reporting or we publicly  
6 report information and now we are in changing  
7 how we pay individual providers and  
8 professionals for their care, based upon that.

9 So that is focused at the provider  
10 level, at the professional level. We spend a  
11 lot of time distinguishing one from another  
12 and so forth that way.

13 But what, at least from my  
14 perspective, we're hoping to get out of this  
15 is not that. We are not trying to measure a  
16 particular hospital. This is about a system  
17 of care.

18 And what I'm just sort of  
19 emphasizing from my stand point, it's not even  
20 about regionalization of care. It's about  
21 measuring the care within a region, within an  
22 area and I'll just give you sort of an

1 example.

2 We have measures that we apply to  
3 hospitals on the time for -- to percutaneous  
4 coronary intervention of 90 minutes. So we  
5 measure that for every hospital in America.  
6 And with those, we publish that information on  
7 the website.

8 We exclude people if they are  
9 transferred and so forth, but it is designed  
10 to say what percentage of patients that come  
11 to this particular hospital will get that  
12 within 90 minutes.

13 When you do it at the system  
14 level, that's not what you are interested in.  
15 You are interested in patients that have the  
16 condition that leads them to fall within that  
17 type of measure to what extent do they get  
18 that if they are in a particular geographic  
19 area or within a system.

20 It doesn't matter what hospital  
21 they go to. It doesn't matter what EMS  
22 service they call. It doesn't matter whether



1 they come by a car or whatever. But we are  
2 interested in how well that emergency system  
3 works.

4 Now, part of it might be  
5 structure. It would be better to have  
6 designated hospitals, perhaps, and stuff like  
7 that, but that is really -- you know, people  
8 might disagree with that or it might not turn  
9 out to be the case. We might think that's the  
10 case, but it may not be.

11 So I just want -- what I don't  
12 think we need necessarily is to be able to  
13 measure the degree to which a system is  
14 "regionalized." What we need to be able to do  
15 is have a framework for measuring the quality  
16 of care. And when we do that, there are  
17 different kinds of measures: Structure,  
18 process, outcome, and cost. And don't forget  
19 about the cost piece of it, because that is  
20 very much on the front burner of concern, at  
21 least at the federal level.

22 I think it is really nationwide,

1 wondering about the cost of healthcare. So  
2 cost -- so I would look at measures that way,  
3 those different things. So structural  
4 measures might be to what extent the people  
5 have transfer agreements and so on and so  
6 forth, but that's really not getting us to  
7 what I think is of greater interest, which is  
8 outcomes, cost, processes of care are  
9 important, but, again, we're sort of de-  
10 emphasizing it at this point.

11 So there I just wanted to make  
12 those points that mainly it's not about  
13 regionalizing care. It's about how well the  
14 care is delivered within a region.

15 CO-CHAIR ROSZAK: Thank you, Dr.  
16 Rapp. I also wanted to extend a very special  
17 thank you and a welcome to Kate Goodrich.  
18 Kate manages the NQF contract for HHS. And  
19 really on behalf of all the HHS family, we  
20 really appreciate the great work you do, Kate.  
21 Would you like to say anything, a few remarks  
22 for the group?

1 MS. GOODRICH: I just want to say  
2 I'm really glad that I was able to come today.  
3 It's great to see this group of people and all  
4 of our -- my federal partners in this effort.  
5 And I appreciate the comments thus far. I  
6 think they are absolutely right on target. So  
7 looking forward to the day. Thanks.

8 CO-CHAIR KELLERMANN: Thank you  
9 very much. Question?

10 MS. TURGEL: Not a question. May  
11 I say a couple words? Sorry. Sometimes HRSA  
12 offices don't necessarily speak to each other  
13 and since I am part of HRSA and Andy, we have  
14 just kind of gotten together, I work for the  
15 Emergency Medical Services for Children  
16 Program, so I just want to make sure that I'm  
17 putting a bug in everyone's ear to make sure  
18 that pediatrics are included.

19 And what we do within every state  
20 and U.S. territory right now, we have  
21 performance measures that they need to report  
22 on. So we will have data in August regarding

1 designation of hospitals within their states  
2 and also interfacility transfer guidelines and  
3 agreements.

4           So we will have some of that  
5 information from every state and U.S.  
6 territory in August. So, please, feel free to  
7 utilize us and I will keep probably hitting  
8 you in the back of the head making sure that  
9 pediatrics are included. Thank you.

10           CO-CHAIR KELLERMANN: Knowing some  
11 of the people around the table, I can assure  
12 you that we will not ignore children. Any  
13 other comments from federal attendees before  
14 we go on with the program?

15           Okay. We are still ahead of  
16 schedule, which is good. And, Dr. Cairns, you  
17 have the floor, sir.

18           DR. CAIRNS: Well, thank you very  
19 much, Dr. Kellermann. And let me just  
20 reiterate what a pleasure it is to be with  
21 you.

22           This has been a project between

1 the Department of Emergency Medicine, the  
2 University of North Carolina, as well as our  
3 colleagues at NQF. And it has really been a  
4 pleasure and, frankly, an honor to be involved  
5 with this project.

6 We are just going to give you an  
7 overview in this session of the environmental  
8 scan. I know that all of you have a copy of  
9 it. And so I'm just going to briefly go  
10 through the process we follow, because it  
11 certainly serves as a resource for our  
12 discussions today on the framework report.

13 And the second aspect was to give  
14 a brief overview of how we approached the  
15 framework draft.

16 Now, there are key components of  
17 the framework draft that, frankly, we think we  
18 need your input on and we want to be sure that  
19 people understand and accept some of the  
20 premises. So there will be more extensive  
21 discussion of those key terms of the guiding  
22 principles and of the domains later on in the

1 day.

2                   So this just serves as kind of a  
3 brief overview, but, please, feel free to  
4 stop. We want this to be a conversation. We  
5 want this to be a discussion and as iterative  
6 as you all find valuable.

7                   So the first slide will just be  
8 the introduction. So this is just directly  
9 out of the environmental scan.

10                  The first comment is that the  
11 premise here is that efficient resource  
12 utilization is paramount to providing  
13 effective quality healthcare.

14                  Second, that this concept of  
15 regionalization has been identified as the  
16 potential method for improving medical care  
17 through this efficient resource utilization.  
18 And you could imagine that one of the key  
19 terms we will be discussing this afternoon is  
20 going to be regionalization, because we just  
21 heard what Dr. Rapp's concept of  
22 regionalization may be and that may differ

1 from some of the current practices of  
2 regionalization.

3 Next slide. And while  
4 regionalization is clearly not a new idea, we  
5 have been serving people across geographies in  
6 an integrated way in trauma, in heart attack  
7 care, stroke care, evolving in cardiac arrest  
8 care, pediatric care, but certainly it has  
9 become a very functional aspect with lots of  
10 heterogeneity.

11 And so honing in on which aspects  
12 are important for quality efficient effective  
13 care across populations and regions will be  
14 the focus of the environmental scan.

15 Next slide. So the National  
16 Quality Forum is engaged in an effort to  
17 establish NQF-endorsed consensus standards  
18 that evaluate the regionalization of emergency  
19 care. So that was the purpose of the  
20 environmental scan. It's to support this  
21 effort.

22 Next slide. And this scan

1 included the review of projects and measures  
2 as well as to identify measurement gaps of  
3 regionalized emergency medical care services.

4 Next slide. The core research  
5 questions that we were tasked with taking on:

6 The first one, what current  
7 performance measures or standards exist that  
8 apply to regionalized emergency care? And at  
9 what level of development or implementation  
10 are these measures?

11 The second key question what  
12 current projects exist in the realm of  
13 regionalized emergency medical care services?  
14 And we felt it important to look at an  
15 overview of projects, because they can provide  
16 a context for these measures and, frankly, can  
17 help inform the context of emergency medical  
18 care services across a wide range of settings,  
19 across a number of different aspects of  
20 systems and across different types of  
21 patients.

22 And then finally, where do gaps



1 exist in current measures?

2 Next slide. So the products of  
3 the scan were to:

4 One, provide a list of performance  
5 measures, both in current use and the  
6 pipeline. And the pipeline has a very  
7 technical term at NQF for these regionalized  
8 emergency medical care services.

9 Describe these existing projects  
10 and then provide an analysis of measure gaps.

11 Next slide. So you could imagine  
12 the task of taking on this issue. While there  
13 isn't a technical definition of  
14 regionalization, and I suspect that we might  
15 have a wide range of opinions on what that  
16 would be, we were guided by consensus  
17 documents that have been recently developed in  
18 order to provide a context for measures.

19 So, first of all, we look for  
20 measures or products of emergency care that  
21 include care that is time-sensitive or of high  
22 acuity. A working definition of high acuity,

1 something that was time-sensitive and was  
2 life-threatening illness or injury.

3 Second, a measure or project of  
4 regionalized care was now within a system that  
5 facilitates delivery of care that is not  
6 universally available. And so, for example of  
7 this, given the acute myocardial infarction  
8 example that Dr. Rapp presented, Aspirin is  
9 pretty much universally available everywhere.

10 PCI or percutaneous intervention  
11 is not. So you can imagine there are going to  
12 be a number of performance metrics in aspects  
13 of that care across settings that are both  
14 uniformly available and wouldn't be included  
15 in this, but then some that are going to be  
16 distributed unevenly across the region or a  
17 population. That would be included as a  
18 measure or project for this screen.

19 Next slide. So the exclusion  
20 criteria is to measure a project for non-  
21 emergency care or that's not within the  
22 regionalized system. And another aspect of

1 this is not just care that is universally  
2 available, but also care that does not involve  
3 a system of both in- and out-of-hospital  
4 components, recognizing that there is going to  
5 be a spectrum of care across these settings  
6 that's going to contribute to a patient  
7 outcome, to a system performance or an  
8 integration across various settings.

9 We're going to talk a little bit  
10 more about that this afternoon.

11 Next slide. So what were the  
12 results? Well, we identified projects and  
13 measures using this evaluation, both  
14 regionalized and emergency care. The Norton  
15 ghost just showed up. It resulted in 11  
16 domains of what we call domains of  
17 regionalized healthcare services.

18 And we had to put in a specific  
19 definition for the technical aspect of the  
20 report and that was now emergency care  
21 treatment of high acuity or life-threatening  
22 conditions in an expedited fashion recognizing

1 that timely care of emergent patients may  
2 prevent mortality or significant morbidity.  
3 That was kind of the standard for the  
4 environmental scan.

5 And so this included out-of-  
6 hospital areas, emergency departments and  
7 other high acuity areas within hospitals.

8 Next slide. So research  
9 strategies. We identified both formal  
10 critical review approaches as well as  
11 reviewing the NQF measurement library. We  
12 reviewed the recent consensus conferences. It  
13 has already been mentioned that the Society  
14 for Academic Emergency Medicine has a recent  
15 consensus conference.

16 The NIH had a series of  
17 roundtables looking at emergency care  
18 research, one on neurology and behavioral  
19 emergencies, another one on medical and  
20 surgical emergencies and a third one on  
21 trauma, emergency trauma.

22 We also noted the IOM workshop on

1 regionalization of emergency care and I had  
2 participated in the ASPR's regionalization  
3 roundtable.

4 After we reviewed those consensus  
5 documents and reports, we then searched out  
6 experts in the areas of EMS, emergency care,  
7 critical care, nursing care, medical care, and  
8 biopreparedness to identify other projects and  
9 measures that weren't captured in the formal  
10 literature consensus conference and  
11 measurement review.

12 These identified measures and  
13 projects were then screened by these inclusion  
14 criteria to find those that might relate to  
15 regionalized medical emergency -- excuse me,  
16 emergency medical care services.

17 Next slide. The scan was done  
18 refined to focus in on these emergency care  
19 issues within regionalized healthcare. When  
20 you do that, the 11 domains become 8.

21 And, next slide, you will get an  
22 example of what this process looked like. So

1 we had 11 domains of regionalized healthcare  
2 that were identified. The first was trauma,  
3 the next was stroke, the third was acute  
4 myocardial infarction, the next one was  
5 cardiac arrest, the next was critical care  
6 medicine, including sepsis and medical shock,  
7 pediatric specialty care, including neonatal  
8 care, toxicology care, specific veteran  
9 affairs networks of care, psychiatric care,  
10 data management perspectives and disaster  
11 preparedness.

12 Then they were filtered by, for  
13 the purposes of, this environmental scan, this  
14 definition of emergency care, which is  
15 healthcare that is provided in an emergency  
16 department or emergency medical services  
17 system or acute care areas of a hospital,  
18 emergency care refers to the treatment of high  
19 acuity and/or life-threatening conditions in  
20 an expedited fashion recognizing that timely  
21 care of emergent patients may prevent  
22 mortality or significant morbidity.

1                   So that was then the criteria for  
2                   which these were screened. Eight domains  
3                   remained, trauma, stroke, acute myocardial  
4                   infarction, cardiac arrest, critical care  
5                   medicine, pediatric specialty care,  
6                   toxicology, and psychiatric care.

7                   And then within those domains, we  
8                   looked for specific project or measures for  
9                   time-sensitive acute or life-threatening  
10                  diseases, definitive treatment is not  
11                  universally available and, therefore, will  
12                  require a systems approach and care that  
13                  relies on both in- and out-of-hospital care.

14                  Next slide. I'm not going to go  
15                  through the numbers. Jeff Williams deserves  
16                  an awful lot of credit, both public and  
17                  ongoing, for literally going through all of  
18                  these sources identifying appropriate domains,  
19                  lumping them into usable groups and buckets,  
20                  applying the filtering criteria and then  
21                  identifying in the tables that you will see in  
22                  the appendices those specific measures, as

1 well as the basis and state of development.

2 Next slide. And so when you do  
3 this, you ended up with a sample frame of over  
4 1,000 measures and the final source was just  
5 210 and that's how we have been able to result  
6 with the final number of measures that are  
7 included in the report.

8 Next slide. Of these measures, if  
9 you look at just where they are, they turn out  
10 to be impressively in acute myocardial  
11 infarction with 11 and then we have got  
12 measures are that are 9 in stroke, 2 in  
13 trauma, 4 in cardiac arrest, 4 in pediatric  
14 specialty care and interestingly, despite the  
15 importance of these other domains, there were  
16 a number of projects, but very few measures.

17 And, frankly, that's the take home  
18 from an environmental scan, is that we did a  
19 fairly broad review of issues in emergency  
20 care and we really did not find a large number  
21 of performance metrics that have been widely  
22 accepted and/or utilized.



1 I know that's probably not a  
2 surprise here, but it's impressive when you  
3 start to quantitate it, given the impact of  
4 emergency care on the health of Americans.

5 Next slide. So does anyone have  
6 any questions about the environmental scan of  
7 what we did? It is completed. It's up on the  
8 NQF website and we certainly hope that it is  
9 valuable. It's a valuable resource as we move  
10 to this phase of the framework report. Jesse?

11 DR. PINES: Thanks, Chuck, really  
12 great work. One of the questions I have and  
13 one of these discussions came up in some of  
14 the small groups for the 2010 Consensus  
15 Conference for SAM, but why was the exclusion  
16 criteria kind of non-time-sensitive  
17 conditions? Why did that come up?

18 And, you know, specifically as we  
19 think about, you know, the overall proportion  
20 of people who come into the ED with these  
21 time-sensitive conditions, it's actually  
22 relatively small compared to the, you know,

1 other folks who were there.

2           You know, specifically, people  
3 with complex medical conditions who actually  
4 may get the care in one system, but they may  
5 be transferred to another system and have all  
6 their testing redone. Was there any  
7 consideration given to looking at care  
8 coordination?

9           DR. CAIRNS: So thank you for that  
10 question, Jesse. We identified a number of  
11 gaps. And one of the key areas that we  
12 identified -- and, again, I would just like to  
13 thank our reviewers and our partners in review  
14 of this document from ASPR, HHS and others.

15           They highlighted some of these  
16 needs in terms of non-emergent care. And so  
17 you will see in the draft of the framework  
18 report that on the last page, 15, No. 27 in  
19 your included documents, we have an area that  
20 we have proposed for future research.

21           And so the need for development of  
22 new measures or adaptation of existing

1 measures to ensure measurement of systems and  
2 not only elements of systems. And we have to  
3 look at both how transitions and  
4 communications between units of service within  
5 regionalized systems work, since most of the  
6 effort has focused in on the individual units  
7 themselves, as Dr. Rapp pointed out.

8 It's not patient interaction with  
9 the healthcare system or a patient symptom to  
10 balloon time and acute myocardial infarction.  
11 It is currently reported as emergency  
12 department to balloon time.

13 So I think we are trying to get to  
14 those broader issues as you have talked of  
15 coordination and communication. And clearly,  
16 structural issues. So emergency department  
17 boarding, crowding, ambulance diversion and  
18 how this affects utilization, as well as how  
19 does this affect utilization in the context of  
20 the growth, of the need and demand for  
21 emergency medical care services, by numerous  
22 folks, including non-emergent conditions?

1                   And then how this will work in the  
2                   development of the healthcare system as it  
3                   undergoes not just response to growth and  
4                   demand, but also evolution in terms of other  
5                   forms of payment.

6                   And then these other areas where  
7                   there may be important quality measures that  
8                   may not have hit the specific disease  
9                   conditions. So, Jesse, that was a long-winded  
10                  answer to say, please, look at the draft  
11                  report on page 15, No. 27 of your materials  
12                  and we expect and hope that we will have a lot  
13                  of input today on those kinds of issues.

14                  Jeff, did you want to add anything  
15                  to that?

16                  MR. WILLIAMS: I agree with Dr.  
17                  Cairns.

18                  CO-CHAIR KELLERMANN: I am so glad  
19                  that people are listening. The floor is open  
20                  for comments or questions. Dr. Martinez?

21                  DR. MARTINEZ: Yes, just to add on  
22                  that comment with Jesse, because I think you

1 were at some of the meetings we have been in  
2 and the big turning point of this was the IOM,  
3 really looking at that group. And what is  
4 interesting, and I just go with your comments  
5 just to give feedback to the Committee, is  
6 Einstein says what you believe is often  
7 determined by what you measure.

8 One of the questions we had was  
9 all these people who get transferred and go to  
10 another facility, what percentage of them are  
11 discharged from the ED, meaning that they  
12 didn't need to be transferred for, at least,  
13 procedural issues?

14 And what we found from going to a  
15 lot of the big data sources, including HRSA  
16 and others, is no one knows, because they  
17 don't measure it. And so it's an important  
18 aspect to look at in terms of performance of  
19 a system, not just a smaller group, but I  
20 think Dr. Corrigan calls them time-sensitive  
21 conditions or something like that.

22 We have a lot of people

1 transferred for belly pain or chest pain that  
2 are really STEMI and so we just should keep  
3 that in the back of our minds as we go  
4 forward.

5 DR. CAIRNS: Rick, thank you for  
6 those comments.

7 CO-CHAIR ROSZAK: Others? Yes?

8 CO-CHAIR KELLERMANN: Looking at  
9 all this from the point of view of acute  
10 neurology and acute neurosurgical issues,  
11 there is really a significant gap in the  
12 measures that are available for that.

13 And if a system ever needed  
14 regionalization, it would be acute  
15 neurosurgical care because the resources are  
16 limited, the facilities are complex and at  
17 least anecdotally, I had knowledge of a lot of  
18 situations where the delay in neurosurgical  
19 care or the absence of neurosurgical care has  
20 led to significant problems.

21 So I would hope regarding what was  
22 just said that we are able to at least try to

1 develop some measures to look at that, because  
2 I think that is a significant weakness in the  
3 entire system dealing with this acute  
4 neurological emergencies that come up and with  
5 the lack of neurosurgeons that are available  
6 to help take care of these problems.

7 DR. CAIRNS: Yes, thank you very  
8 much. In fact, we think this is an important  
9 area, both in the general area of trauma, as  
10 well as in specific conditions. And then  
11 imagine if you run across into environmental  
12 spectrum from pediatrics to geriatrics, there  
13 is clearly going to be a need.

14 CO-CHAIR KELLERMANN: Brendan?

15 DR. CARR: Chuck, I wonder if you  
16 -- the task that was given to you was to do an  
17 environmental scan to see what the label end  
18 was. I get that. But I wonder if it a little  
19 bit pigeonholes us into, you know, repeating  
20 the past instead of drawing a blank slate and  
21 thinking about how we could restructure this.

22 And I think that's a trap that we

1 should address early on, because if we were  
2 happy with the system we had, we probably  
3 wouldn't have asked you to go back and look at  
4 it.

5 But in asking you to go back and  
6 look at it, we are starting from, you know,  
7 the past.

8 DR. CAIRNS: Brendan, excellent  
9 point. And I'm going to use that as a  
10 transition. So let's go to the framework  
11 report, because I think that this is a  
12 critical learning that we got from the  
13 environmental scan is that in a very  
14 comprehensive formalized approach, we found  
15 this relative paucity of information and  
16 measures.

17 And we know that there are huge  
18 gaps and needs. And I think that this  
19 framework report can provide a pathway if not  
20 explicit direction on where we might go to  
21 address those concerns.

22 So here is now just a brief



1 overview of the draft. Again, you all have a  
2 copy of it. And we are going to go over some  
3 very important components of this draft later  
4 on today, but just to provide an overview then  
5 about how we decided to framework these issues  
6 in a draft report for your consideration  
7 comment.

8           So the first was provide a context  
9 and direction to key healthcare system  
10 stakeholders regarding the evaluation of  
11 regional emergency medical care systems. So  
12 at least put in context for you all to give us  
13 input on what you think is important and what  
14 those key issues might be we need to address,  
15 Brendan, in order to move forward.

16           Second is propose a mechanism to  
17 identify the current measurement landscape  
18 within regionalized emergency medical care  
19 systems, as well as gaps and measurement. So  
20 now that we have had a formalized review of  
21 what is out there, what should it look like  
22 moving forward?

1                   And then to identify what  
2 performance measures are needed in this  
3 evolving area of healthcare? And hopefully,  
4 and we are convinced, that parts of this  
5 framework, if not all of it, will serve as a  
6 catalyst for the future development of  
7 measures and measure concepts, because it's  
8 just too important for us not to utilize this  
9 approach.

10                   So that's at least a broad  
11 overview, Brendan, in order to try and take on  
12 some of those key issues you have identified.

13                   Next slide. So the way that we  
14 have outlined this, and, again, this was in  
15 conjunction with NQF and our federal partners,  
16 was to approach it by getting the definition  
17 key terms down. This is the third promissory  
18 note I have said that we are going to address  
19 it, but we will address it.

20                   Important terms, emergency care,  
21 regionalization, these kinds of issues. We  
22 are going to delineate the purpose.

1                   Next. We are going to introduce  
2 an episodes of care paradigm. This is a care  
3 paradigm that NQF has found valuable as they  
4 take on new areas of healthcare to identify  
5 measures. And I do think there is  
6 applicability to emergency medical services  
7 care, but there are some limitations.

8                   Next. To identify some domains of  
9 measurement for regionalized emergency medical  
10 care services.

11                   Next. To generate guiding  
12 principles which may not only provide guidance  
13 to this framework report, but to future  
14 endeavors in this area. And so we will spend  
15 some time in terms of what those might be.

16                   Next. And then to develop  
17 criteria for evaluating the measures within  
18 the framework. And to be used as a basis for  
19 the draft, the current NQF guidelines. They  
20 clearly have been successful in developing and  
21 guiding the implementation of care guidelines  
22 across a wide range of areas and clearly

1 taking the approach to emergency medical care  
2 services in a regionalization paradigm could  
3 be a valuable start.

4 Next slide. So we did want to  
5 introduce this idea of the episode of care  
6 approach. And this again is included in the  
7 draft framework report that you all have  
8 access to. And in this approach, you have a  
9 population at risk, this is called the Phase  
10 1 aspect. There is the evaluation initial  
11 management of disease, a Phase 2. And then  
12 there is a follow-up care or a Phase 3.

13 So in this generic episode of  
14 care, there are three specific phases. One  
15 might call the first phase prevention, second  
16 phase evaluation, initial management,  
17 including potentially emergency care, and  
18 Phase 3 follow-up care, outcomes and further  
19 intervention.

20 So then at the end of the episode,  
21 you look for risk adjusted health outcomes,  
22 mortality, clearly one of them, but also

1 functional status and then in line with Dr.  
2 Rapp's discussion risk adjusted total cost.

3 So in the evaluation of  
4 appropriate times throughout this episode, you  
5 look at key patient attributes for risk  
6 adjustment, informed patient preferences, the  
7 alignment of the care processes with these  
8 patient preferences and the assessment of  
9 symptoms, functional and emotional status.

10 So we are going to briefly talk  
11 about how we applied that in this draft to  
12 regionalized emergency medical care services.

13 Next slide. So in this paradigm,  
14 we took the example of an acute myocardial  
15 infarction. So you could imagine that a Phase  
16 1, while valuable, we don't do as much with  
17 risk adjustment, prevention, although there  
18 may be an opportunity in Phase 1, certainly in  
19 Phase 3.

20 But one thing that you can do in  
21 preparation for an episode of care with a  
22 patient would be to have a regionalized system

1 or at least an encompassing system within a  
2 geography and a population that designates  
3 where needed resources are.

4 So in the case of acute myocardial  
5 infarction, where the cath labs are that are  
6 available 24 hours a day, seven days a week  
7 and can provide timely care to patients  
8 delivered there.

9 Another example of what you can do  
10 prior to the onset of a clinical episode is to  
11 have an emergency medical services triage and  
12 destination protocol for STEMI, so that the  
13 paramedics, the 911 and ambulance folks know  
14 where they are going to take a patient who has  
15 an acute myocardial infarction, independent of  
16 where they live or who they are.

17 A third potential component is to  
18 have a communication technology that will  
19 enhance and guide care or the care continuum  
20 from EMS, emergency department, cardiology,  
21 hospital resources.

22 So those are all components of

1 this Phase 1 that are all in place prior to  
2 the clinical episode of acute myocardial  
3 infarction.

4 So within this Phase 2 now that  
5 the patient has symptoms and dials 911 is how  
6 can we earlier identify acute myocardial  
7 infarction, in particular STEMI ST segment  
8 elevation acute myocardial infarction, a time-  
9 sensitive type? Can that be done by EMS  
10 personnel? What are the care process measures  
11 that contribute to early identification?

12 What are the care process measures  
13 that are consistent with high acuity care that  
14 are life saving, for example, in an episode of  
15 acute myocardial infarction? What are the  
16 timeliness measures, recognizing that time and  
17 mortality are closely linked in this  
18 condition?

19 How do we optimize communication  
20 between the units of service, between the EMS,  
21 emergency department, cath lab and any  
22 specialty services required? And then what

1 are the standards of care that are necessary  
2 to provide high quality appropriate care to  
3 patients with acute myocardial infarction and  
4 how that should be coordinated across these  
5 different specialties?

6 And then the Phase 3 approach  
7 would be post-percutaneous intervention ICU  
8 care and what measurements would be relevant  
9 to appropriate care and outcomes? Care  
10 coordination measures across these varied  
11 units of care including rehabilitation and how  
12 do we enhance communication between providers,  
13 both within the acute episode of care and  
14 potentially with the care provided by a  
15 community health provider?

16 And the end of the episode could  
17 be everything from death, functional status,  
18 neurologically intact and so on. So when you  
19 look at appropriate times throughout the  
20 episodes, we have got patient-oriented  
21 intermediate outcomes. We looked -- assure  
22 transitions across these units of service



1 during this episode of care and that we have  
2 appropriate measurement to facilitate  
3 comparison across similar regionalized systems  
4 in different organizations.

5 And, Jeff, you spent some time  
6 coming up with what some of the challenges and  
7 limitations of this model are. Could you  
8 highlight some of those?

9 MR. WILLIAMS: Sure, of course. I  
10 did want to add two other comments as well  
11 before we talk about limitations.

12 The first was, one, I think  
13 benefit of the episodes of care approach is it  
14 allows us to be patient-oriented. I think at  
15 the end of the day, we are looking at  
16 improving the quality of care delivered to a  
17 patient. And so we felt that this was a good  
18 model to be able to take a patient through a  
19 system from when a care episode, using the  
20 term, begins all the way through to, as Dr.  
21 Martinez points out, he is either discharged  
22 after transfer, which is, obviously, not the

1 optimal outcome, or receives definitive care.

2           So we thought that, and I think  
3 Dr. Carr made an excellent point, applying to  
4 this model, I think where we have gone in the  
5 past, at least as much as I have been able to  
6 catch up and read in this area, is essentially  
7 Phase 2. And we are evaluating care and we  
8 are looking specifically most of the time at  
9 process measures, but looking at this sort of  
10 episodes of care model allows, first of all,  
11 the measurement of structures and systems that  
12 are in place, potentially in Phase 1 and then  
13 also allows evaluation of post-care  
14 coordination, did care occur the way that it  
15 should have, etcetera, potentially in Phase 3.

16           Clearly, this is a little bit of a  
17 paradigm shift from the initial episodes of  
18 care approach developed in some of the prior  
19 NQF-endorsed frameworks. But this is how we  
20 sort of envision the episodes of care approach  
21 working in this area.

22           So as you chew on that for two

1 seconds, I'm going to flip to the limitations.  
2 I think that, first, one, I think to put this  
3 in context, benefit about episodes of care  
4 that I just said is, essentially, you are  
5 looking at care that occurs to a patient sort  
6 of almost in real time.

7 The episodes of care approach  
8 doesn't necessarily, and I think that there  
9 are ways to address this, focus on whether  
10 that care was appropriate. So I think Dr.  
11 Martinez' point about whether or not, for  
12 example, a transferred patient is cared for  
13 appropriate towards the end of the episode,  
14 may be something to emphasize, potentially in  
15 Phase 3 or wherever.

16 But I think one potential  
17 limitation is that the model does not  
18 necessarily focus on whether care was  
19 appropriate. You know, EMS provider  
20 identifies a STEMI. The patient is taken to  
21 the cath lab. The cath is done. The patient  
22 goes to the post-ICU, post-PCI ICU care and

1 gets excellent care.

2 Well, you know, are we focusing on  
3 whether or not that patient actually needed to  
4 go to the cath lab? That's sort of a -- that  
5 may not be the best example, but the point is  
6 that limitations arise when you consider  
7 measuring care across the board. You don't  
8 necessarily address whether or not the care  
9 needed to occur in the first place.

10 A second limitation is that if --  
11 you will focus on the box at the bottom  
12 regarding emphasizing measurement to  
13 facilitate comparison across similar  
14 regionalized systems. So a regionalized  
15 trauma system in one area of the country may  
16 be very similar and have similar outcomes to  
17 a trauma system in another part of the  
18 country, but individual efficiencies and  
19 individual practices in each system are not  
20 necessarily highlighted by evaluating simply  
21 one episode of care in one system.

22 So I think that as we consider

1 this model, we should put a special emphasis  
2 and find some place to put comparison between  
3 systems, so that those efficiencies can be  
4 shared and potentially impact systems across  
5 the country.

6 I think those were the two main  
7 limitations we thought about. Clearly, there  
8 are potentially others that I'm sure some of  
9 you will address, but we hoped, basically, to  
10 provide a comprehensive model that would allow  
11 for structural issues that come up, process  
12 issues that come up to be, at the very least,  
13 categorized with this model. Thanks.

14 DR. RINNERT: Hey, Jeff, don't you  
15 think that if we -- as we go forward and we  
16 are looking at -- you are worried about sort  
17 of the overarching concepts contributing to  
18 our missing the fidelity within individual  
19 regions. In other words, there are some  
20 regions that do things very well at the  
21 grassroots level.

22 And by comparing them or looking

1 at them sort of with overarching brushes, you  
2 may miss that fidelity. As we drill down and  
3 get to the individual measurements that we  
4 developed, won't some of that loss of fidelity  
5 go away or not?

6 MR. WILLIAMS: Well, I think so.  
7 I think that's an excellent point. I think  
8 when you drill down to the measure level and  
9 you assume that measures are going to be  
10 applied similarly across systems, that that  
11 will go away.

12 As Sally pointed out earlier  
13 today, I think that the point of this  
14 conference, to some extent, is to look at the  
15 framework as a whole. So I agree with you.  
16 I think that some of that will go away,  
17 assuming that the measures are specific enough  
18 to apply across systems.

19 But I think that the framework  
20 should somehow address your point. You should  
21 perhaps state that explicitly or state that,  
22 you know, while we realize that there are

1 some, you know, trees lost for the forest,  
2 that that will happen over time as the  
3 framework is implemented in a given system.

4 DR. CAIRNS: So if I could just  
5 follow up briefly on that? I think it's a  
6 really important comment, so imagine that you  
7 have a system where the paramedics can read  
8 the 12 lead ECGs and then determine the next  
9 available hospital. And they have decided to  
10 distribute both the hospitals and the  
11 paramedics in a geographically uniform way, so  
12 the access to care is similar across that  
13 system.

14 That would then require a  
15 measurement of absolute time from interaction  
16 with 911 to say balloon time, as in -- as a  
17 measurement of the performance of the system,  
18 as opposed to just saying we have a triage  
19 destination policy in our system and,  
20 therefore, meet the required performance  
21 metric.

22 So I do think that when you put it

1 on an absolute scale, you can find optimal  
2 kind of measurements, but there may indeed be  
3 structural measurements that aren't  
4 necessarily linked to absolute changes and  
5 outcomes in an episode of care.

6 DR. WRIGHT: Jeff and Chuck, I'm  
7 curious if you had an opportunity to apply the  
8 model to domain -- one of the domains that is  
9 not condition-specific and, for instance, more  
10 developmentally-specific? And the reason I  
11 ask is just to give you a concrete example,  
12 the vanishingly small number of children with  
13 time-sensitive conditions actually show up at  
14 a place for definitive care at initial  
15 presentation. Only 2 to 3 percent of severely  
16 injured children show up at a pediatric trauma  
17 center, for instance, initially.

18 So I'm wondering about the ability  
19 of this model to incorporate a heavy dosing of  
20 interfacility -- of triage beyond EMS in the  
21 facility, interfacility transport to  
22 definitive care, the kind of activity that



1 would be more germane to a population-based  
2 time-sensitivity occurrence than a condition-  
3 specific occurrence where we are looking for  
4 a triage at the field level and appropriate  
5 disposition there.

6 DR. CAIRNS: And, Joe, thank you  
7 for that example. In fact, we played a little  
8 bit around with the pediatric model as well  
9 for episode of care and again look forward to  
10 the input of this group as to whether or not  
11 these examples are valuable as we approach the  
12 framework.

13 But I'm going to move back to this  
14 particular example, because in many cases, and  
15 in North Carolina we track every emergency  
16 department visit. We also track every EMS  
17 visit of every patient every day. So we have  
18 actually been looking at how this happens  
19 across a state.

20 And it's remarkable how many STEMI  
21 patients are taken from the field to a  
22 hospital that doesn't have a PCI capability

1 and are then transferred to another one.

2           So I think it is somewhat  
3 analogous to the pediatric trauma patient who  
4 gets sent initially to a hospital with the  
5 thought of stabilization, again, just for a  
6 descriptive term and then gets transferred for  
7 definitive care at another center.

8           And I think the wisdom of that  
9 strategy, I think, may need to be addressed.  
10 Certainly, one of the aspects as we look at  
11 optimizing systems, back to this example in  
12 acute myocardial infarction, is that there is  
13 some thought of doing direct field to resource  
14 appropriate hospital transport directly as  
15 opposed to going through an intermediate  
16 hospital.

17           And you can imagine if you look at  
18 a timeliness measure under Phase 2, the third  
19 one, that you get much lower times with direct  
20 field triage to resource-specific hospital  
21 than going through the intermediary community  
22 hospital.

1                   So, Joe, I think this is a really  
2                   important aspect to look at. And I think it's  
3                   one of the key components, at least we  
4                   identified, in using this framework.

5                   MR. WILLIAMS: I would just add  
6                   one other comment in answer to that question.  
7                   I don't think that the episode of care  
8                   approach is necessarily limited to, in this  
9                   way, a particular place that the episode has  
10                  to begin.

11                  So clearly, when dealing, for  
12                  example, with pediatric specialty or any other  
13                  specialty for that matter, I think that an  
14                  episode of care can begin whenever the need  
15                  for a regionalized system is identified. I  
16                  don't think it necessarily has to begin when  
17                  you are -- the kid's belly starts hurting at  
18                  home or when 911 is involved.

19                  I think that the episode of care  
20                  can begin, you know, whenever the need for the  
21                  system is identified, whether that be in the  
22                  ED, whether it be on the floor in terms of

1 understanding the need for transfer to a  
2 higher level of care.

3 I think that's a good point. We  
4 should probably address that.

5 CO-CHAIR KELLERMANN: I have a  
6 process suggestion and that's going to be,  
7 given that we all have these cute name tags,  
8 when you have a question, if you will put it  
9 sideways, that will give me a sense of the  
10 queue. I'm not sure these things won't fall  
11 over, but we will try that.

12 And so there is a hand here and  
13 then we will go to you next.

14 MR. COOPER: Thanks. I want to  
15 build a little bit off of Joe Wright's  
16 comments and also the comments made by our  
17 colleague from CMS, both of which take off, I  
18 think, from some of the concepts that were  
19 first enunciated or not first enunciated, but  
20 strongly enunciated at the IOM Regionalization  
21 Conference.

22 You know, regionalization is not

1 centralization, necessarily speaking, in some  
2 cases it may well be. But it is a reality of  
3 life that not every region is going to have  
4 every resource immediately available to every  
5 patient. And even if it did, the patient  
6 might not choose to avail himself or herself  
7 or his or her child, you know, of that  
8 resource.

9 And so I think in building any  
10 sort of episode of care model, we really have  
11 to pay very close attention to the issue of  
12 sustentative care, not just definitive care.  
13 You know, what can we do to begin the process,  
14 you know, efficiently and effectively, you  
15 know, in effect, at the first receiver level,  
16 so that the process of care can begin in an,  
17 you know, appropriate fashion?

18 That's a -- I recognize that's a  
19 slippery slope because, of course, when  
20 patients end up in non-definitive care  
21 facilities getting definitive care, if they  
22 are getting sustentative care, they tend to

1 stay there longer than they might. And that  
2 too can impact upon outcome.

3 But I just urge this as we go  
4 forward thinking through this model that to  
5 remember that we can't just be thinking about  
6 the definitive care piece of it. And, you  
7 know, all the bells and whistles that, you  
8 know, you have listed by example in this  
9 episode of care model. Thanks.

10 DR. CAIRNS: Can I comment just  
11 briefly, Arthur? So we agree with you. And,  
12 in fact, I think this also speaks to Jesse  
13 Pine's point on non-emergent care just because  
14 we have decided to come up with a technical  
15 definition of emergency and, again, we look  
16 forward to this group's input on what that  
17 might be.

18 If you look back at the previous  
19 slide, if you could do that, Eric? If you  
20 look under appropriate times throughout  
21 episode is No. 2 bullet "Assessment of  
22 informed patient preferences in the degree of

1 alignment of care processes with these  
2 preferences."

3 And we need to keep that in mind.  
4 And I think it is into the NQF version of the  
5 framework and how that applies to our  
6 framework, I think will be very important to  
7 continue.

8 MR. WINGROVE: I'm wondering if  
9 there is any intent to exclude any  
10 geographical parts of our country? And the  
11 reason I ask that is one of Dr. Cairns'  
12 comments about going -- and the PCI center.  
13 There are lots of places in this country where  
14 going to the PCI center, the first time is  
15 absolutely the wrong thing to do.

16 And so one of my interests, being  
17 kind of a rural guy, is making sure the system  
18 rewards people for doing the right thing. And  
19 sometimes that is not going to the specialty  
20 center the first time.

21 DR. CAIRNS: Thank you, Gary, I'm  
22 smiling. This is a research question that we

1 have had in North Carolina since you all may  
2 be familiar, we have regionalized STEMI care  
3 voluntarily in the state. And we actually  
4 have areas of the state where thrombolytics  
5 are given by paramedics because the time to  
6 get them to a PCI center physically is just  
7 too difficult.

8           Having said that, I think you can  
9 move it from PCI to say reperfusion therapy.  
10 And how do you then optimize reperfusion  
11 therapy to resources, geographies and  
12 populations, if time is an important  
13 component? But let's not forget that, Gary.  
14 This is a really important issue.

15           And our hope is to not exclude any  
16 region of the country. Our experience has  
17 been to be inclusive in our state. Remember,  
18 we have mountains, we have coast and we have  
19 got some rich urban places, but we have,  
20 unfortunately, got some very poor rural  
21 places. So I hope that we will maintain those  
22 discussions.



1 CO-CHAIR KELLERMANN: Nick, did  
2 you want to comment?

3 MR. NUDELL: I think you are  
4 starting to address where my concern was also.  
5 From the pre-hospital perspective, many  
6 episodes of care sort of require you to know  
7 the diagnosis in advance or at the beginning.  
8 And from the pre-hospital perspective, that's  
9 relatively uncommon to start with that  
10 approach.

11 So could you address that, please?

12 DR. CAIRNS: Nick, thank you very  
13 much. One of the premises of emergency care,  
14 and I think we need to reinforce this in the  
15 definition, is that we deal with  
16 undifferentiated patients. And for example,  
17 in acute myocardial infarction, when you start  
18 looking at populations and geographies  
19 inclusive, you find very different answers.

20 So one of the benefits of our  
21 state is that we can look at all these  
22 complaints as they show up in emergency

1 departments and it turns out that less than 50  
2 percent of patients over 80 who present with  
3 acute myocardial infarctions present with  
4 chest pain.

5 And you compare that to 85 percent  
6 in patients less than 40 years-old. So you  
7 even have to be careful on a symptoms-based  
8 approach along differentiated illness and  
9 injury. And I think that is a key component  
10 that we need to recognize, that patients don't  
11 present with diagnoses. They present with  
12 conditions.

13 And we really want to address that  
14 in terms of our definition of emergency, for  
15 example, if you all agree.

16 CO-CHAIR KELLERMANN: Chuck, I've  
17 got a few questions, but I will weave them in  
18 whenever we have lags. But I will start at  
19 the beginning, which is back to environmental  
20 scan for a moment.

21 There are a number of AHRQ-funded  
22 evidence practice centers in the country that

1 have done systematic reviews over the last  
2 several years. I have got the privilege of  
3 working with one in southern California. I  
4 think RTI has one close to you all.

5 And they have a very structured  
6 process for ascertaining literature and  
7 filtering documents. Did you all follow that  
8 process or is your process different? And the  
9 reason I say this, in my little piece of this  
10 world, which is cardiac arrest, your scan did  
11 not pick up all of the really noteworthy  
12 reports.

13 And so the current draft is  
14 excluding a couple of papers that I think --  
15 and data systems there were very relevant. So  
16 I'm just wondering how you got to the measures  
17 that you did and whether, in fact, there may  
18 be others in some or the other domains that  
19 are also not quite -- haven't made the report  
20 yet?

21 DR. CAIRNS: Art, thanks for those  
22 comments. Number one, we didn't follow that

1 formal approach. I'm familiar with it. I was  
2 part of the technical center at Duke for RTI  
3 in terms of looking at some of those issues.

4 To be honest, Art, I think if we  
5 did that, we would find even less measures  
6 than we found. Now, having -- we did set up  
7 certain parameters though that may have  
8 excluded some of the measures that you thought  
9 should be identified.

10 We ended up with over 1,000  
11 projects and measures. But as we went through  
12 the filters, we did put very specific filters  
13 on it. We put through the filter that it had  
14 to fit our definition of emergency, that it  
15 had to fit our definition of system. And then  
16 it had to fit both emergency and system in  
17 order to be included as a project or as a  
18 measure.

19 So there are a number of  
20 measurements, for example, in cardiac arrest  
21 that are clearly valuable, time to  
22 defibrillation. One of the challenges, of

1 course, is how does that apply across the  
2 system?

3 And so we are trying to come up  
4 with components of how we would put specific  
5 process measures in this broader regional  
6 context. We have gotten it wrong, Art, and we  
7 look forward to further suggestions on how we  
8 might include it.

9 A second key component were those  
10 things that we named that are systems and  
11 structural and process issues. So, for  
12 example, another component of cardiac care are  
13 these systems, such as the Ontario-based  
14 projects on advance cardiac life support where  
15 an entire system has been put together and  
16 demonstrated an impact on outcomes.

17 If there is components  
18 unidentified to a system approach, then they  
19 wouldn't have made it into our screen, but  
20 clearly, they are effective when applied. So  
21 how we can identify measures and even  
22 projects, then form those measures, would be

1 very valuable. So I would look forward to  
2 your inputs.

3 CO-CHAIR KELLERMANN:

4 Specifically, I'm thinking, you know, you have  
5 OPALs, ROCs, several others, but the CDC Care  
6 Registry is not cited. We have known for 15,  
7 20 plus years that return to spontaneous  
8 circulation is not only a proximate outcome  
9 measure for a well-functioning EMS system,  
10 911, bystanders, first responders and  
11 paramedics, but it is by far the most potent  
12 predictor for a successful outcome with good  
13 neurological status at discharge and neither  
14 of those made the cut for the first draft.

15 So I -- and that's -- I don't want  
16 to dive into the weeds too soon, but it would  
17 seem to me those are examples of the process.  
18 If -- and that's leaving aside a whole other  
19 conversation we will have later, which is  
20 where are the holes that we need to be  
21 conceptually advising NQF as we go forward  
22 where we don't have measures today, but want

1       them. That is what, at least, jumped out to  
2       me.

3                       There may be others in other  
4       domains, but that's the one that I know best.

5                       DR. CAIRNS: Those are good points  
6       on all those. We clearly are aware of the  
7       OPAL group and I intersect with the ROC group  
8       and I'm going to let Dr. Sayre comment on how  
9       many of those findings have come out in terms  
10      of measures and performance measures that are  
11      used for that purpose.

12                      I know are dropping the standards  
13      in the emergency care coordination -- excuse  
14      me, the Emergency Cardiac Care Guidelines  
15      Group has been doing a lot of work with that.

16                      DR. SAYRE: I kind of agree with  
17      Dr. Kellermann, in that I think part of it  
18      gets to the definition of what you mean by a  
19      system here. So if what you are saying is  
20      that the measure has to touch maybe two  
21      different organizations at some level, that's  
22      perhaps the threshold here for something to be

1 included.

2 I'm reading, but I also think that  
3 there are probably measures that impact what  
4 happens to patients further down in that  
5 system, that if they are not optimized in the  
6 beginning, and I think that was part of what  
7 the comment was over here, they're not going  
8 to allow for high quality care to happen  
9 later.

10 CO-CHAIR KELLERMANN: Ron? And  
11 then we will go to you, Tom, because your side  
12 has been --

13 DR. CAIRNS: And I just wanted to  
14 point out --

15 CO-CHAIR KELLERMANN: Go ahead.

16 DR. CAIRNS: -- that if you look  
17 at the list of projects, the entire American  
18 Heart Association Cardiac Arrest Guidelines  
19 are listed as a cardiac arrest project.

20 CO-CHAIR KELLERMANN: Ron?

21 DR. MAIER: Just to further flog  
22 this point, I agree completely with your



1 concern. And as an extension, one of the  
2 things about -- and before I start, I have to  
3 give you -- this is a great document. And I  
4 congratulate you on your effort. It's a  
5 phenomenal effort and it's sort of always  
6 going to be somewhat deemed for failure,  
7 because you know you're going to be able to  
8 set up the parameters and actually capture  
9 completely.

10 But I think that's what the group  
11 is here for is to add individual experiences  
12 and fill in some of the gaps that are obvious.  
13 But continuing with our theme, the only things  
14 that bother me a little bit about your  
15 approach, which I agree with, I like the  
16 episode of care. I think it's a great way to  
17 sort of look at the system.

18 But it leaves off a big hunk of  
19 the front end and I don't know how far we want  
20 to go with that and that is access. So if you  
21 want a buzz word in medicine these days,  
22 access to care has got to be there, because

1 this can become an increasing challenge.

2 And as you know, 20 years ago at  
3 the CDC when we were debating trauma systems  
4 and we had this big final fight as we came down  
5 to inclusive versus exclusive as opposed to  
6 using the regionalization word, the concept  
7 was divided around the access issue.

8 And I think it's something we'll  
9 resolve with the inclusive system that's  
10 allowed the access for that patient. It had  
11 sort of missing in your approach right now.  
12 I think you can add it on and I think the  
13 group needs to decide how far towards access  
14 they want to go, because that can be another  
15 whole topic.

16 And again, I don't know where the  
17 group wants to go, but I think it's something  
18 we should explicitly define, we're either  
19 going to go there or not, because right now,  
20 it really isn't dealt with very much.

21 And as an extension of that, the  
22 impact which you allude to, but don't really

1 go into, is the impact of disasters on access  
2 in the system. And again, that may bog us  
3 down for the next two months and we may not  
4 want to go there, but I think, explicitly, we  
5 should deal with the concept and put it where  
6 we want to put it.

7 DR. CAIRNS: Ron, thank you very  
8 much. And what a key issues. And so we talk  
9 about infrastructure, we talk about diversion.  
10 We talk about overcrowding. We talk about  
11 rural versus urban. Really, we are talking  
12 about access. And I think that we need to  
13 address it.

14 How we address it, I think, is  
15 going to be a little challenging, because I  
16 think we are going to have to -- when you try  
17 to do a scan for performance measures in these  
18 things, it becomes challenging, especially if  
19 you want to have them have an impact on  
20 mortality or significant morbidity.

21 However, that doesn't mean that we  
22 don't need them. And I think the framework

1 can provide an opportunity to identify those  
2 areas where we need better performance metrics  
3 and we can define what some of the key gaps  
4 are.

5 You had made another important  
6 point. Did I address your questions, Ron?

7 DR. MAIER: I don't think there is  
8 an answer you can give. I think it's  
9 something the group, I just think, needs to  
10 wrestle with, because I think it's something  
11 that we need to come up with at the end of the  
12 two days.

13 DR. CAIRNS: Oh, disaster,  
14 disaster. Thank you, sir. I agree. And so  
15 disaster, now, imagine the idea of across a  
16 geography and a population, regionalized  
17 emergency care where there is a surge or there  
18 is an overwhelming incident and you can  
19 imagine that you could have even an episode of  
20 care approach to such a thing, because you  
21 have got preparedness, you have got response  
22 and then, of course, you are going to have to

1 figure out the plan and integration for the  
2 next one.

3 And, unfortunately, we have had  
4 too many examples where we haven't done Phase  
5 3 after that.

6 CO-CHAIR KELLERMANN: Chuck, just  
7 a quick point of clarification. As Ron said,  
8 nobody is here to criticize you or Jeff for  
9 the report, but to contribute and because  
10 we've got three cards up and I'm sure we will  
11 have more, you are welcome to respond if you  
12 think there is an immediate, but also, I just  
13 want to make sure we get all of the ideas out  
14 on the table, so NQF staff and the group can  
15 hear them, particularly as we barrel into  
16 lunch.

17 So we have got three and we'll  
18 just move around so there will be Tom, and  
19 then Kristi and then John.

20 MR. LOYACONO: Thank you. I  
21 wanted to piggyback on Gary's comment about  
22 the system doing the right thing in the first

1 place. You know, destination and location of  
2 the incident is not the only variable. If you  
3 have services that are not available in the  
4 first place, it could change the  
5 appropriateness of going to a place for  
6 stabilization versus going on.

7 And a part of that is  
8 communication and making sure that the right  
9 resources are sent in the first place. In  
10 many systems, there are no choices in very  
11 rural areas and in many systems an early  
12 decision has to be made. And I think all that  
13 has to be a part of whether or not the measure  
14 was appropriate, given the circumstances in  
15 that area at that time. I hope that makes  
16 sense.

17 MS. HENDERSON: Yes. I just  
18 wanted to make sure that we include discussion  
19 about telehealth, the regionalization access  
20 to care, all of these issues cost. We can't  
21 always take the patient to the expertise.  
22 There is a lot of times we are going to have

1 to do the opposite.

2 And there is a lot of  
3 sophisticated telemedicine networks across the  
4 country that we could look into and explore  
5 how we could build off of that.

6 CO-CHAIR KELLERMANN: You are  
7 being quite modest. I believe that you all  
8 run one of the most sophisticated in the  
9 country.

10 MS. HENDERSON: We do, in  
11 emergency medicine.

12 CO-CHAIR KELLERMANN: John?

13 DR. FILDES: I just wanted to  
14 build on what Art said and that I think that  
15 the environmental scan is excellent and well-  
16 thought out. I was surprised to see that only  
17 two performance measures surfaced in trauma,  
18 considering its history back to 1966 and the  
19 number of studies done.

20 I'm sure there are lots of reasons  
21 for it, including even that some of that early  
22 work was never computerized.

1                   But I would mention though that  
2                   the systems guide written by the college is  
3                   probably the most recent iteration, "The  
4                   Living Organ," of the 2008 HRSA document. And  
5                   it contains over 100 citations in it. It  
6                   would be -- and I'm sure that you have waded  
7                   through that, but there are many measures that  
8                   are in there that are currently in use that  
9                   have actually proven their worth, but somehow  
10                  escape recognition by the methodology that was  
11                  used.

12                  So I just bring that up as a  
13                  point.

14                  DR. CAIRNS: Yes, these are good  
15                  points, John. And it's one of the challenges,  
16                  because, you know, we identify projects, so  
17                  you will see that, you know, we have pretty  
18                  broad swaths of projects. So, you know,  
19                  similar, you know, to cardiac arrest, clearly,  
20                  there are guidelines and there is evidence-  
21                  based and there is a lot of different  
22                  components to it.



1           The translation of those into  
2           measures that have -- you know, that then have  
3           reduction in mortality or significant  
4           morbidity is where some of the challenge in  
5           our screen comes up. So that does suggest  
6           that there are clearly successful endeavors  
7           that are going on.

8           And frankly, we recognize trauma  
9           as the earliest and potentially one of the  
10          most comprehensively studied. So how we  
11          translate those projects, those learnings,  
12          those findings into performance metrics that  
13          kind of meet these criteria, I should tell you  
14          that one of the -- we didn't go into our next  
15          level of performance metric evaluation,  
16          because NQF has a very formalized approach to  
17          what is an acceptable measure.

18          But some of the things that we  
19          look at are things that not just have evidence  
20          behind them, but that they are not universally  
21          applied and, therefore, have incremental  
22          value. And there are a number of other

1 components, performance metrics that we think  
2 may be valuable for acute care.

3 We cited one of our papers from  
4 2008 in emergency medicine regarding that, but  
5 that's just something for this Committee to  
6 discuss.

7 DR. FILDES: Can I follow-on?

8 CO-CHAIR KELLERMANN: Yes.

9 DR. FILDES: I think it's  
10 important as a group that we don't lose focus  
11 on some other things. And I use this example  
12 often, the Injury Foundation's Guidelines, I  
13 believe it is Chapter 2, "The Use of Oxygen."  
14 It says that "There is no evidence to prove  
15 that oxygen is useful."

16 The study was never done. You  
17 can't prospectively randomize people to be  
18 hypoxic or not. There are going to be some  
19 things that are just evident that may not be  
20 captured with a rigorous approach like that.  
21 But I don't think that they can be dismissed  
22 out of hand.

1 CO-CHAIR KELLERMANN: Kathy?

2 DR. RINNERT: I wonder, if maybe,  
3 at this point, it's reiterative that I think  
4 we are sort of tying together the inclusive  
5 system and the issue of access, because they  
6 really are one in the same. And then that,  
7 obviously, parlays into the comments from our  
8 -- the group that is watching from over here  
9 that has to do with then building systems  
10 capabilities and capacity to deal with it.

11 Not every hospital needs to be  
12 able to do everything for everyone. And yet,  
13 we would expect that there are at least some  
14 basics that can be accomplished to determine  
15 whether or not this person needs more  
16 subspecialty care and pass them further down  
17 the line.

18 What those metrics are to say that  
19 it is an inclusive system, to say that it is  
20 access rich versus on that sort of is more  
21 relegated to preventing patients from having  
22 access, I don't know what those metrics are,

1 but that certainly would be one -- an  
2 overarching principle that I think we need to  
3 address. And it certainly wasn't something  
4 that you all set out to do in your project,  
5 but would be something that I think would be  
6 of value.

7 DR. CAIRNS: Can I briefly  
8 respond? Yes, when we looked at just kind of  
9 our intellectual approach, so I'm amongst  
10 friends and I know they are on the phone, too,  
11 we really sought to identify what would be  
12 potentially unifying themes across a  
13 regionalized emergency care system.

14 So the first kind of threshold was  
15 those conditions for those patients in whom it  
16 has been proven that time is a key component  
17 and time measured in hours and minutes, not  
18 days, weeks and months, and that there is  
19 evidence for reducing death.

20 And so when you start taking a  
21 look at other issues, such as access and  
22 process and structure, that there are going to

1 be some challenges.

2 Our, again, intellectual approach  
3 initially was well, what are those structures  
4 and processes that help support the care of  
5 those time-sensitive life-threatening  
6 conditions?

7 So that is not inclusive. And we  
8 recognize that the evidence may not be there  
9 in a regular fashion for very important  
10 conditions. And we have already discussed the  
11 idea of non-emergent conditions in a disaster  
12 plan in surge.

13 CO-CHAIR KELLERMANN: Jesse?

14 DR. PINES: Thanks for those  
15 comments. One of the issues, key issues,  
16 which comes up logistically with performance  
17 measurement is the attribution to a particular  
18 system or hospital or physician. When it  
19 comes to regionalized emergency care, this  
20 becomes a real challenge because, you know,  
21 when someone comes into an emergency  
22 department in a hospital and you are trying to

1 get that patient to the cath lab quickly, you  
2 kind of know who the players are in that  
3 system and if there is a delay, you can figure  
4 out what happened and attribute it to the  
5 hospital who ultimately is responsible for all  
6 those players.

7           When it comes to transferring  
8 patients between different systems, now, you  
9 are talking about EMS. You are talking about,  
10 you know, bringing -- pulling that back to  
11 closer to when the emergency actually starts.  
12 Then the level of attribution becomes a lot  
13 more complex, because it may be that a delay  
14 could happen at any of the parts of the  
15 system.

16           And, ultimately, the question is  
17 are these measures intended to be applied to  
18 hospitals, regions? I mean, where -- I don't  
19 know if there has been a lot of discussion  
20 about where there might --

21           DR. CAIRNS: Jesse, good point.

22           And, clearly, we have a lot of internal

1 discussions on it. And so one of the filters  
2 that we put is that it needed to be a system  
3 and it needed to have different settings  
4 contribute to the outcomes.

5 And so antibiotics for pneumonia,  
6 for example, wouldn't make it in our  
7 measurement framework, despite evidence that  
8 has been presented in its adoption as a  
9 national metric, because antibiotics are  
10 pretty universally available and the system is  
11 within the emergency department.

12 So that was at least the basis of  
13 the scan. You know, there are critical  
14 components that could occur outside of the  
15 hospital, like I'll go back to defibrillation  
16 times where, you know, there is clearly  
17 evidence to show they are beneficial. What  
18 that time might be and how you attribute that  
19 to the system, the paramedic, the 911 group,  
20 the availability of AEDs, these are  
21 challenging questions.

22 CO-CHAIR KELLERMANN: Chuck, given

1 that I see no cards up, I'll take the Chair's  
2 prerogative and launch another question.

3 Let's take the episode of care  
4 paradigm for a moment. And I look at the  
5 document and I see you have pulled out  
6 candidate measures or domains. I'm not sure  
7 I see yet much clarity about where holes might  
8 be.

9 And let me give you sort of -- put  
10 this into an episode of care, if you will, for  
11 a moment as to possibilities. Imagine that I  
12 am a patient with severe pulmonary edema  
13 developed over 15, 20 minutes. I call 911.  
14 I'm hypoxic. I'm in ventilatory failure.

15 I would want to know from a  
16 quality perspective, first of all, if the  
17 hospitals in my areas have been designated as  
18 to whether or not they are a cardiac receiving  
19 center with the various modalities and skills  
20 to manage. So designation of capabilities.

21 I might like to know whether that  
22 hospital is, in fact, available, because it is



1 not so overloaded with patients that it is on  
2 diversion or the cath lab is, in fact, open  
3 and staffed and the cardiologist isn't either  
4 in the cath lab tied up or on the back nine of  
5 the local golf course, and, therefore, not  
6 available to intervene.

7 I would like to know whether or  
8 not the paramedics have to call each hospital  
9 individually to find one who can take me or  
10 whether they can call a single number or radio  
11 or look on their dashboard of their ambulance  
12 and know that my hospital is open and  
13 available or is not for whatever reason.

14 I would want to know whether I got  
15 diverted once, twice or three times before I  
16 ended up finding a hospital that was able or  
17 willing or had to take me in.

18 And then, obviously, I would like  
19 to know much more basic performance measures  
20 like time from I dialed 911 to the point that  
21 I did receive PCI or whatever, definitive care  
22 I needed.

1                   And most importantly, I would like  
2                   to know, ultimately, whether I lived or died  
3                   and had a decent outcome.

4                   Some of those, I think, are in the  
5                   candidate list now. Others aren't yet and  
6                   maybe because we don't have good ways of  
7                   measuring and many regional systems don't have  
8                   these capabilities today, what are your  
9                   thinking and your colleagues about sketching  
10                  those sorts of measures out, particularly  
11                  issues again of capability, capacity,  
12                  diversion, some of these performance metrics  
13                  that could really potentially have a very  
14                  major effect on outcomes.

15                  And I might have missed them when  
16                  I went through.

17                  DR. CAIRNS: No, you didn't. And  
18                  we think they are critical. And, in fact, we  
19                  think that's the real value of the framework.  
20                  So I'm going to go back to the episodes of  
21                  care paradigm though and say that I think it  
22                  could encompass an awful lot of those

1 components.

2 I think it can encompass whether  
3 or not that hospital has the structure and  
4 staffing to handle a wide range of acute  
5 cardiac emergencies or let's make it broader  
6 to critical care emergencies.

7 I think that you could have a  
8 component of what the communication systems  
9 are between these units of service, such as  
10 EMS and emergency departments in order to be  
11 able to match patient need with available  
12 resources.

13 And I think that would also speak  
14 to a lot of issues in terms of emergency  
15 department capacity and capability and how it  
16 communicates with EMS to match during times of  
17 stress or surge or diversion the needs of  
18 patients with its availability.

19 And there were a number of other  
20 key components within that episode of care  
21 that I think could be put in this framework  
22 for Phase 1, structures, systems.

1 I think the other issue, in fact,  
2 I took down Dr. Rapp's comments here of  
3 structural process outcomes and cost and I  
4 think we could probably, if the Committee is  
5 interested, put a component of that in each  
6 one of those phases, because I think you hit  
7 it.

8 Undifferentiated patient with  
9 shortness of breath. Wide range of potential  
10 needs and causes. Time-sensitivity given it's  
11 an acute condition. And now, we have got to  
12 understand how that episode of care plays out  
13 across those units of service within that  
14 geography, understanding time and life-threat  
15 are going to intersect in the needs of this  
16 patient.

17 Is that a fair enough synthesis?

18 CO-CHAIR KELLERMANN: Yes, I think  
19 so. We have got three signs up now, so we'll  
20 move up the table this way. Dr. Martinez, you  
21 are up.

22 DR. MARTINEZ: Yes. Just very

1 quickly. As unaccustomed as I am to being  
2 heretic, I'm glad you made that last comment,  
3 because I wanted to mention that with Mike.

4 You know, the current system as it  
5 stands right now, we don't measure a lot of  
6 things talking about gaps. And, to me, the  
7 cost issue is a big one, because the system,  
8 as it sits right now, is killing a lot of our  
9 hospitals. It's just killing them.

10 And so, you know, what we proposed  
11 several years ago was to flip it around, so  
12 that it was a two-way system and not a one-way  
13 system.

14 But I'll tell you, Chuck, I just  
15 stepped down a role. I had 103 hospitals and  
16 probably half of those were rural. And we  
17 have gotten to the point to where they  
18 transfer as much as they admit.

19 DR. CAIRNS: Yes.

20 DR. MARTINEZ: And those patients,  
21 as you follow them up the chain, and our  
22 surgeons were great about that looking over

1 triage, because they wanted to get rid of that  
2 because of the cost involved with that, the  
3 vast majority of those patients are discharged  
4 from the receiving facility.

5 So it's really not a procedural  
6 issue. So I really wanted to put it on the  
7 radar screen.

8 CO-CHAIR KELLERMANN: Rick, it  
9 just occurred to me, I'm not sure everybody  
10 would follow. You talked about the system  
11 that's killing our hospitals, you are talking  
12 about a system where everything goes to the--

13 DR. MARTINEZ: Yes.

14 CO-CHAIR KELLERMANN: -- big  
15 central hospital as opposed to --

16 DR. MARTINEZ: Because the natural  
17 end of this is we're going to build a 40 story  
18 building in the midwest Omaha and we are going  
19 to just transfer everybody there.

20 And so what happens is that the  
21 smaller facilities are losing their  
22 capabilities and their knowledge and

1 everything else, the patients aren't  
2 repatriated and so, you know, I go back to Dr.  
3 Carr's comment, is that if we put the measures  
4 to reinforce what is already done, then we end  
5 up with that issue of people won't see the  
6 effects until we can't correct it.

7 So I just think the cost issue has  
8 to be in there somewhere.

9 CO-CHAIR KELLERMANN: And that  
10 fits again into Kristi's comment earlier about  
11 do we have systems to get information decision  
12 making to the bedside of these first  
13 hospitals?

14 DR. MARTINEZ: We started talking  
15 last week.

16 CO-CHAIR KELLERMANN: Right,  
17 right.

18 MS. HENDERSON: Okay. Can I  
19 comment to that?

20 CO-CHAIR KELLERMANN: Yes.

21 MS. HENDERSON: When we  
22 implemented our telehealth, we had that same

1 problem. Everyone was being transferred to  
2 our one trauma center in the state, most of  
3 them discharged.

4 Now, we have a 20 percent increase  
5 in local admissions to the rural hospital,  
6 because we have helped them stabilize, feel  
7 comfortable with the patients and they don't  
8 have that expertise, because they only get one  
9 cardiac arrest every three months, so they  
10 lose that. And they are not comfortable, so  
11 they want them out.

12 So telehealth just can support  
13 that and keep them in their rural area.

14 DR. MARTINEZ: And, Chuck, just  
15 the measure we may not have it, but I threw it  
16 out there, is that the capacity of the system  
17 rises when that communication -- you have been  
18 very good about mentioning communications and  
19 those links, those hand offs.

20 But you see that with TeleStroke,  
21 that they over-transfer everybody and over  
22 time the knowledge goes up and they are able



1 to discern better what needs to go and not go.  
2 And so the local hospital becomes better, but  
3 it is also our key access points in America.

4 CO-CHAIR KELLERMANN: So, for  
5 example, playing on that thought, if we are  
6 measuring things like moving of patients, we  
7 might also consider measuring the movement of  
8 CT images, so that we can make clinical  
9 decisions where the doc or nurse practitioner  
10 in a small hospital can say this patient does  
11 not need to come to me. This patient can be  
12 managed by you at your local -- you know, et  
13 cetera.

14 So I hear what you are saying.  
15 Brendan and then Jesse or you took your sign  
16 down.

17 DR. CARR: I was wondering and I  
18 don't know who to even direct this question  
19 to, but if someone could tell me if this is  
20 outside of the scope of what we should be  
21 talking about, I think that's okay. But I'm  
22 sitting here thinking about how this will be

1 someday operationalized.

2           And I wonder if that needs to  
3 impact the way that we talk or think about  
4 these things. And specifically, I'm wondering  
5 in the world of the ACO when -- if it makes  
6 sense to be thinking about how the episode of  
7 care model interacts with the world of the  
8 ACO.

9           Are we thinking that multiple  
10 hospitals, independent of payer, are going to  
11 be jointly held accountable for the outcomes  
12 of patients in whatever that catchment that  
13 Jesse was referring to is? Are all the  
14 hospitals in my hometown of Philadelphia  
15 jointly responsible for the cardiac arrest  
16 outcomes of the city?

17           And somehow CMS incentivizes or  
18 disincentivizes the communal performance,  
19 because it's hard for me to get my head around  
20 how the end piece, who pays the bill at the  
21 end of it is related to the Phase 1 building  
22 of the system.

1 DR. CAIRNS: So first of all,  
2 really good comments. And I think that they--  
3 frankly, just a quick comment on cost,  
4 telemedicine, resource matching and  
5 potentially implementation.

6 We recognize that a lot of these  
7 issues are challenges. And if you take a look  
8 at the last few pages of the draft framework  
9 report, we put in some criteria for evaluating  
10 measures. And these are from the NQF's  
11 perspective. And then we put a little bit of  
12 a spin on it and we cited it.

13 The key components are is it  
14 important as a contributor to quality of care,  
15 scientific acceptability or, you know, how  
16 does the measure define strength of evidence,  
17 the validity, the usability?

18 In other words, how meaningful are  
19 they going to be to attend in audiences? And  
20 what's the relationship between the measured  
21 use and the outcome? And is it of sufficient  
22 magnitude to make a difference? And is it

1 feasible?

2 Do we have the data readily  
3 available across the systems of care? And is  
4 it cost-effective to implement the measure?

5 So, obviously, I assume in the  
6 telehealth world that you all found it to be  
7 useful, feasible and valuable. And that may  
8 be independent of the scientific validity of  
9 the approach.

10 And there may also be other  
11 aspects where feasibility is just not  
12 available in order to do it. But I think the  
13 idea of connecting patients with units of  
14 service to effectively, efficiently and cost-  
15 effectively provide their care may be a  
16 valuable theme for this group to consider.

17 MS. TURBYVILLE: I would like to  
18 add to that. Because this is a measurement  
19 framework effort, it also provides a fantastic  
20 opportunity for all of you to inform where the  
21 data platforms should be going.

22 So if there is an ideal set of

1 measurement that you can understand or intuit  
2 today, for example, but you realize that it  
3 might not be feasible right now, we still  
4 would like that captured in this framework  
5 report.

6 It also serves as an important  
7 signal, you know, getting all of you together  
8 of where we might want to continue pushing in  
9 order for those measures to then be feasible  
10 and usable in the future. So do not limit  
11 yourself with just what we are able to do now,  
12 but, yes, continue to push us. We want to  
13 capture that in this report.

14 CO-CHAIR KELLERMANN: Dr. Maier?

15 DR. MAIER: Also just because we  
16 don't have so much time, but you talk about  
17 inappropriate transfer. Saturday night or  
18 Sunday morning, I got a transfer in from  
19 Anchorage by Lear jet and talk about somebody  
20 that doesn't need to be there to be discharged  
21 and then figure out how to get back to Alaska  
22 without any money, I mean, the system we have

1 is really great at optimizing rural impacts.

2 But what I wanted to say is an  
3 extension of what Art was saying when he gave  
4 his great example of I think you can use as  
5 you argue to talk about using the episode of  
6 care to try and figure out what we don't know.

7 But there is an amazing overlay to  
8 that. And I think again, something which we  
9 should address and that is I think it almost  
10 has to be disease-specific driven on top of  
11 the regionalization plan and that is, you  
12 know, a trauma system may be perfect to answer  
13 all of their parallel questions that Art  
14 asked, but then they have nothing to do with  
15 the same question with an acute cardiac event.

16 And it may or it may not, but I  
17 think some how we have to build a system that  
18 can analyze that the cardiac patient is going  
19 to go through the regionalization  
20 appropriately and cost-effectively the same  
21 way the trauma patient, using potentially  
22 totally different hospitals.

1                   And the system has to be able to  
2                   feed that correctly to optimize the current  
3                   outcome.

4                   And then as the last extension,  
5                   somebody had mentioned earlier we just don't  
6                   want to reproduce the past. And I think it  
7                   was also mentioned that it is time to move on.

8                   One of the things that Chuck puts  
9                   in his report is that he implies from his  
10                  review that the system that has the most risks  
11                  under its name, such as stroke or MIs, is  
12                  therefore the most mature and advanced, which  
13                  I would argue with.

14                  Because one of the things we have  
15                  done in the last 30 years is we went through  
16                  a lot of that process monitoring approach and  
17                  that is if acute subdural is not operated on  
18                  four hours, the process was not met and it's  
19                  bad care. And as you know, it's all those  
20                  that disappeared over the last 30 years,  
21                  because they don't hold up as carved in stone  
22                  approach to monitoring quality of care.

1                   And I think actually the longer  
2 list means you haven't been in the game long  
3 enough to figure that out and that as we also  
4 heard process may be time to move on and  
5 actually start looking at outcomes that are  
6 valid markers for the system. And if the  
7 system can produce a great outcome, then we  
8 can start looking at the components to  
9 individualize and make each of those better.

10                   CO-CHAIR KELLERMANN: I would say  
11 yes and in measuring outcomes in episodes in  
12 a true regional system, whether we define  
13 regional in terms of populations or geography  
14 that it is population-based.

15                   So it's not just the outcomes of  
16 the 100 patients that we know about, but the  
17 150 that we aren't capturing today. And  
18 that's what Mike Rapp properly said before the  
19 start of the morning. He said from a CMS  
20 perspective, we want to know how are  
21 communities doing managing life-threat X as a  
22 community?



1 I already know whether or not Dr.  
2 Martinez can manage the patient with life-  
3 threat X in front of him, but I want to know  
4 can the community optimize outcomes within  
5 their population for people with that life-  
6 threatening condition?

7 That requires a different data  
8 collection strategy than just the referral  
9 center and its registry in order to capture  
10 that type of information.

11 Nick, you are up next.

12 MR. NUDELL: The conversation  
13 reminds me of the question I asked on our  
14 telephone call about the definition of a  
15 system or a region and I know that that's a  
16 million dollar question.

17 But for example, I know of  
18 hospitals that are licensed hospitals within  
19 their state, but are unable to accept  
20 obstetrical patients or other -- there is many  
21 hospitals where the physician is a family-  
22 practice physician at home and is called to

1 the emergency room and has 30 minutes to get  
2 there.

3 There are a lot of different kinds  
4 of systems and different ways that they are  
5 implemented, so having some measurement or  
6 some way to compare could be important for  
7 helping those systems to mature or change or  
8 find the ideal way to implement their system.

9 DR. FILDES: Sally, I want to  
10 thank you for your comments and this follows  
11 on to some of the others. And so, I mean, in  
12 grappling with what your goals are in  
13 measuring care in the regionalized system, you  
14 know, I'm getting the idea that really what  
15 you are trying to do is just to, you know,  
16 capture the background of what is happening as  
17 opposed to taking an FAA approach to, you  
18 know, having a top down set of directives  
19 within specters and standards and so forth and  
20 so on.

21 Am I right in that? You're trying  
22 to get a population-based background count and

1       what emergency care looks like? And then back  
2       into what is happening in the region? Because  
3       that's different from the FAA approach, which  
4       says tomorrow we are going to write a book  
5       that says what do you need for STEMI?

6                   And then we are going to send a  
7       bunch of people out to make sure that there  
8       are hospitals that can do it. And then we are  
9       going to measure whether or not they are doing  
10      it.

11                   DR. CAIRNS: I can answer it from  
12      our perspective and get Sally's reflection.  
13      So this is a process. All right. So the  
14      environmental scan, remember we came up with  
15      those criteria. We came up with a search  
16      approach and proposed it and just used that as  
17      kind of an information document, right? Just  
18      to show what would happen if one were to use  
19      that approach now.

20                   Clearly, the framework, I think,  
21      is to kind of identify where we are, where we  
22      need to go, where do we have mature

1 opportunities? Where do we need to develop  
2 some?

3 And I think that there will be an  
4 ongoing process beyond that before a specific  
5 measure comes out, is endorsed, much less  
6 implemented towards Brendan's comments. But,  
7 Sally, I'll defer to you.

8 MS. TURBYVILLE: I think how you  
9 stated it is right. We are looking to set a  
10 framework, not a strict set of rules about  
11 what it is going to look like. We want to  
12 signal to measure developers. We want to  
13 signal to those who are building the systems,  
14 those who are maintaining them how we might  
15 evaluate and assess as we continue to improve  
16 quality of care that is paying attention to  
17 the resource allocation throughout our system.

18 So I think it's a fair way to  
19 think about it.

20 DR. FILDES: My next question  
21 would be what data system is going to be used  
22 to collect data?

1 MS. TURBYVILLE: So NQF doesn't  
2 collect the data or develop measures, right?  
3 So what we are trying to do is get the experts  
4 together that will help inform those who then  
5 do look to build the data system to help  
6 inform those who do develop the measures.

7 So that's a good question and I  
8 think to the extent that there are  
9 recommendations or suggestions that come out  
10 of this expert group, we would want to share  
11 that with that community within our quality  
12 enterprise.

13 CO-CHAIR KELLERMANN: Mr.  
14 McCullough and then Dr. Kusske.

15 MR. McCULLOUGH: Just in follow-up  
16 to the invitation that Sally has made about  
17 looking out of the box a bit more. One of my  
18 concerns is just in general in the barriers  
19 and implementation. And I'm just going to  
20 pick my home State of Georgia here.

21 Our noncompliance now with so many  
22 things that have been the national standards

1 for decades and I think no matter whatever  
2 system we create, until we can get at the  
3 local level, the fire chiefs, the EMS  
4 directors, the hospital administrators, who  
5 are willing to give up their perceived market  
6 shares, then we are not going to have success  
7 at whatever is created.

8 And so I'm hoping that's something  
9 that may come out of this as well is whether  
10 we increase our stakeholders at the table, but  
11 unless we get the buy-in from fire chiefs and  
12 local EMS directors who are going to be  
13 willing to embrace the national standard and  
14 to even follow any kind of national  
15 guidelines, then I'm afraid a decade from now  
16 we are still here, still not implementing what  
17 was approved 20 years ago.

18 CO-CHAIR KELLERMANN: Dr. Kusske?

19 DR. KUSSKE: Taking that a step  
20 further, one of the issues that has retarded  
21 the development of regionalization and systems  
22 is the EMTALA laws. And the EMTALA laws have

1 -- until recently, the regulations have not  
2 specified how CMS would approve of community  
3 call systems and community is a large term.  
4 It doesn't necessarily just refer to a city,  
5 but it may refer to a state.

6 And whenever this is done, I think  
7 the -- we are going to have to pay attention  
8 to those regulations, because they will  
9 certainly affect whether any regionalization  
10 system is effective or not.

11 And so I think that needs to be a  
12 consideration. It's a little bit tangential  
13 to what you are talking about, but it's a key  
14 issue that has to be dealt with, I believe.

15 CO-CHAIR KELLERMANN: Arthur?

16 MR. COOPER: I can't stand my tag  
17 up, because it's on the floor, so forgive me.  
18 I want to build a little bit off of Ron  
19 Maier's comments. We have had a lot of  
20 experience in New York State with population-  
21 based trauma registry.

22 And as Ron has indicated, one of

1 the things that we have discovered is that  
2 unless you are actually doing the individual  
3 risk adjusted measures for the individual  
4 diseases that you wish to study, you are not  
5 going to have a true picture of what is going  
6 on.

7 The hospitals that you would think  
8 on the basis of, you know, academic  
9 excellence, high volume, etcetera, are not  
10 always the best performers. In fact, there  
11 are many, many performers that have low  
12 volumes and aren't publishing a whole lot of  
13 papers that have outstanding risk adjusted  
14 mortality statistics.

15 Now, developing a population-based  
16 trauma registry, you know, with all the bells  
17 and whistles and collecting data on every  
18 single, you know, patient, is difficult  
19 enough. When you multiply that by X number of  
20 emergency conditions, you know, it becomes  
21 really a formidable task. Easier now with an  
22 electronic medical record.



1                   But one of the things that we have  
2                   learned is that if administrative data is  
3                   constructed in a way that it includes at least  
4                   an initial set of vital signs from the first--  
5                   you know, from an emergency department visit,  
6                   a first set of vital signs builds in the  
7                   physiologic component, therefore, the time-  
8                   sensitive component, that plus, you know, a  
9                   few basic items of interest from the emergency  
10                  department record, coupled with the discharge  
11                  data abstract data set that is available in,  
12                  you know, virtually every single state and  
13                  territory, at this point, gets pretty darn  
14                  close in terms of the reliability of the data  
15                  to which you would get with a trauma registry.

16                  So I think as we look towards the  
17                  future, and I'm, you know, thinking of Sally's  
18                  comments here, unless we are really looking at  
19                  the outcomes, unless we use the tools that we  
20                  have, maybe enhance them very slightly across  
21                  the board, you know, we are going to be  
22                  missing, I think, a great deal of opportunity

1 for improvement.

2 DR. CAIRNS: Can I make a brief --  
3 just a brief comment?

4 CO-CHAIR KELLERMANN: Yes.

5 DR. CAIRNS: I agree. I mean, I  
6 think that we clearly need to have the data  
7 systems in place. I think they have to  
8 recognize how we cross the units of service.  
9 Then we have to think about what an episode of  
10 care is and where it starts and where the  
11 critical elements of the data are required to  
12 evaluate that episode of care.

13 And, you know, I like the  
14 emergency department vital signs. Imagine if  
15 we presented that to the EMS vital signs for  
16 those that intersect first with the EMSes.

17 CO-CHAIR KELLERMANN: Chuck, it's  
18 always dangerous when I don't see name tags  
19 up, because it gives me an opportunity to ask  
20 another question or two, but as we roll into  
21 lunchtime, because I feel like with no obvious  
22 candidate for toxicology or for mental health

1 at the table, could you talk for a moment  
2 about the "absence of any measures" in either  
3 of those domains?

4 I think I was struck at the  
5 comment in the draft that while we didn't see  
6 anything for acute psychiatry, because it sort  
7 of is available everywhere, and I might have  
8 thought you would have said it's sort of  
9 available nowhere.

10 And so given that we don't have an  
11 emergency psychiatrist at the table, could you  
12 just elaborate for a moment on what either  
13 wasn't there or what needs to be there to  
14 capture behavioral health, which is an  
15 enormous challenge in this country, a major  
16 cause of morbidity and a not inconsequential  
17 cause of mortality from suicide, family  
18 violence and the like?

19 DR. CAIRNS: Absolutely. I agree  
20 with both your comments that psychiatric care  
21 is a big challenge and needs to be addressed.  
22 I would hope it would be addressed in the

1 framework and toxicology.

2           So in psychiatric care, I think  
3 one of the challenges in terms of looking at  
4 measures from an NQF perspective is that they  
5 are just not there. And that doesn't mean  
6 that they shouldn't be there.

7           So imagine the components that  
8 would be important. One would be how to match  
9 patients with need. How to address acuity.  
10 How to develop interventions that are  
11 impactful within a time frame, especially  
12 identify any of those that are associated with  
13 short-term mortality or severe morbidity.

14           And then the issues that we have  
15 discussed here in terms of access,  
16 infrastructure, a regionalized approach,  
17 including recognition of geography and all-  
18 inclusive patient populations would seem to me  
19 to be a good start.

20           And if I were to take a look at  
21 the episode of care, I can imagine that the  
22 Phase 1 would be to be sure that there is a

1 system of identification of where psychiatric  
2 emergency patients intersect with system and  
3 how they are best served.

4 Phase 2 would potentially include  
5 everything from evaluation and risk  
6 ratification to communication between  
7 emergency and psychiatric providers, between  
8 resources available and patients required,  
9 guarding the need and I would hope to develop  
10 some standardized care that would show an  
11 impact on outcomes.

12 And then the Phase 3 side is to  
13 figure out how we can intersect the system,  
14 the entire emergency system to better serve  
15 this population of people with a huge chronic  
16 demand for service where severity is clearly  
17 demonstrated. That's the first shot.

18 Secondly, on toxicology. You  
19 know, toxicology does have a series of papers  
20 and a series of conditions where time has been  
21 shown to make a difference. So, for example,  
22 it would be bicarbonate and tricyclic

1 antidepressant toxicity and there is a time-  
2 sensitivity to it, there is a characterization  
3 intervention mortality reducing effect.

4           So most of it is based on  
5 electrocardiogram characterization. And so  
6 EKGs are fairly universal and bicarb is fairly  
7 universally available. How that integrates  
8 though into a geography of say poison control  
9 centers and serves every patient within a  
10 population or geography, so that they can get  
11 the benefit of that time-saving intervention,  
12 would be an example of another episode of care  
13 approach.

14           So Phase 1 would be how do you  
15 intersect poison centers and other readily  
16 accessible information system? How do they  
17 either determine destinations or triage or  
18 similar to your telemedicine approach to apply  
19 to populations?

20           And then for an episode of care,  
21 how does that system then deliver patients to  
22 the appropriate care setting to get that life-

1 saving intervention?

2 So I think you can use the episode  
3 of care framework for both of those  
4 conditions. Dr. Kellermann, I do think that  
5 I appreciate Dr. Maier's approach that  
6 disease-specificity may be important.  
7 Although, I recognize the EMS paradigms that  
8 patients don't necessarily differentiate  
9 themselves.

10 And so we have got this challenge  
11 of undifferentiated conditions that is really  
12 going to be a key component, all-inclusive  
13 geographical-based systems and maybe there are  
14 going to be strategies that can do it, whether  
15 it's telemedicine, whether it is EMS, triage,  
16 whether it is some new form of systems.

17 Nine-one-one to me seems like  
18 another opportunity, just because it's an  
19 immediate access point. Those are initial  
20 thoughts here.

21 CO-CHAIR KELLERMANN: One could  
22 imagine measures like suicide within 24 hours

1 of an emergency department visit as a measure  
2 of bad outcome. Another might be a length of  
3 time from presentation to emergency department  
4 to admission to an inpatient unit for  
5 involuntary commitment currently measured in  
6 days, rather than hours in many communities.

7 DR. CAIRNS: In fact, you are  
8 absolutely right. And, you know, during this  
9 scan, you can imagine the universe of  
10 potential things one could look at in this.  
11 So, you know, like the sad person scale, which  
12 is supposed to be a --

13 CO-CHAIR KELLERMANN: Right.

14 DR. CAIRNS: -- suicide predictive  
15 scale, you know, if we could have a valid  
16 specific applicable measure that has been  
17 proven to make that difference, that could be  
18 universally applied, well, I can imagine that  
19 would be a great performance metric.

20 And so, for example, NIH just put  
21 out a recent U01 to try to develop that so it  
22 could be applied. And so, obviously, that



1 would then be a wonderful measure for us to  
2 consider or certainly a gap to identify.

3 CO-CHAIR KELLERMANN: Okay. We  
4 will go to Helen and then to Howard and then  
5 we are going to break for lunch. This is a  
6 very energetic session.

7 DR. BURSTIN: Great. Just one  
8 overarching comment as you think through their  
9 framework and the domains and the sub-domains.  
10 It is important to consider which kinds of  
11 measures could actually live in a non-disease-  
12 specific mode and which ones require that they  
13 don't.

14 I would argue a good number of  
15 these cross-cutting domains, like care  
16 coordination and communication, I would hope  
17 you would not have us wind up with thousands  
18 of measures for every disease entity.

19 DR. CAIRNS: Great point.

20 DR. BURSTIN: And instead think  
21 about what is cross-cutting and what works  
22 best, especially considering there is a team

1 approach for many of these.

2 And then specifically though, four  
3 conditions where you think that is really  
4 important, I would argue those should be  
5 branches off this framework and then identify  
6 the key domains and sub-domains for those key  
7 areas. But otherwise, you wind up with  
8 literally care coordination measures for every  
9 condition and that's not optimal either.

10 CO-CHAIR KELLERMANN: We are going  
11 to indulge my traumatic colleague from  
12 Washington State here for a moment.

13 DR. MAIER: Because I'm being  
14 traumatized. No, but I just wanted to  
15 reemphasize what you said. I think you are  
16 absolutely correct. In fact, if anything, if  
17 you look at the current processes and  
18 standards that are being used, they are sort  
19 of picked for diseases being totally different  
20 and they shouldn't be.

21 I mean, the vast majority should  
22 be standardized across and I think that's a

1 big thing that is missing as seen in the  
2 survey is that we haven't done that.

3 CO-CHAIR KELLERMANN: Howard, you  
4 get the last word.

5 MR. KIRKWOOD: Okay. Well, this  
6 is more in the nature of food for thought and  
7 since it's time for food, I'll be brief.

8 One of the bits of background  
9 noise that is having -- giving me some  
10 difficulty getting my head around all of this  
11 points to the need to, you know, sort of begin  
12 with the end in mind.

13 And I'm kind of cluttered by how  
14 are these going to be used, because a lot of  
15 the discussion we have had, you know, I think  
16 there is somebody who has used the word pay  
17 for performance before in the background and  
18 there is other compensation issues, so it  
19 would help me focus in on the target if we  
20 could talk a little bit more about how these  
21 are going to be used.

22 The second point we have talked

1 about a variety of domains and we haven't  
2 mentioned patient or customer satisfaction in  
3 there. And I think the greatest system you  
4 develop will fail if the people who are  
5 supposed to use it, hate it. So satisfaction  
6 is an issue.

7 And third, and I'm glad you  
8 brought up the example you did, when we talk  
9 about EMS, I would like folks to keep in mind  
10 that EMS is more than just transporting  
11 patients to hospitals.

12 We have just undertaken a project  
13 among its pieces utilizes EMS providers in the  
14 field to get mental health patients to the  
15 right resource, rather than just delivering  
16 them all to the back door of the emergency  
17 department.

18 In our community, a mental health  
19 patient will consume a monitored ED bed for 14  
20 hours before they can be replaced. And when  
21 we did the arithmetic the other day, we had  
22 made enough room for 500 additional chest pain

1 patients to be evaluated by keeping those  
2 people out of the ED.

3 So there is a lot more to be  
4 contributed by them than transportation.  
5 Thank you.

6 CO-CHAIR KELLERMANN: It reminds  
7 me of another historic document courtesy of  
8 NHTSA, the "The EMS Agenda for the Future,"  
9 which talked about a number of these topics  
10 many years ago.

11 Okay. That was an excellent  
12 morning session. We are going to break for  
13 lunch. We reconvene at 12:45. And my  
14 colleague Mr. Roszak will chair the first half  
15 of the new session.

16 (Whereupon, at 12:03 p.m., the  
17 above-entitled matter went off the record and  
18 resumed at 12:54 p.m.)

19  
20  
21  
22

1 A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

2 12:54 p.m.

3 CO-CHAIR ROSZAK: All right. If  
4 we could start making our way back to the  
5 chairs, we will get back underway. Amazingly,  
6 we were pretty well on schedule this morning.

7 You AMS guys break it up back  
8 there. All right. Well, thank you all for  
9 getting back. I hope you enjoyed your lunch.

10 Skip, do you have some opening  
11 remarks to start off the afternoon?

12 MR. KIRKWOOD: Thanks. Just  
13 following up on my closing remarks, we are  
14 talking about high level framework kind of  
15 stuff here. And one of the thoughts that  
16 evolved over lunch, after a couple of  
17 discussions was, you know, maybe we are not  
18 looking at one set of measures, maybe we are  
19 looking at two.

20 One being the actual performance  
21 of the system and the other being something  
22 that looks like a capability index. Because

1 again, going to where we think this is headed,  
2 pay for performance and adjustments of  
3 compensation, you know, the best any given  
4 regional system can do is the best it can do.

5 And that may not be the same as  
6 the region next door. So just a thought.

7 CO-CHAIR ROSZAK: Very good.

8 Well, thank you. I'm glad to hear that it was  
9 a working lunch. So we are going to move into  
10 the definitions section and I believe we have  
11 some PowerPoint visual aids for this section.

12 So I will turn it back over to our  
13 folks at UNC to kind of lead us through the  
14 definitions. And remember, like I said  
15 before, these are very much working  
16 definitions, but they are definitely subject  
17 to modification. So if you do see some things  
18 that stick out and would like to make a few  
19 amendments here and there, we are certainly  
20 open to that as well.

21 So, Chuck, are you going to be  
22 leading the way?

1 DR. CAIRNS: My pleasure, Andy.

2 So we talked about in the framework concept  
3 that there were key terms and definitions that  
4 really needed to be decided upon. And we  
5 realized that there have been a number of  
6 attempts to define these terms.

7 But in recognition of the  
8 functional aspects of this project, we felt it  
9 was important to get something down on paper,  
10 a minimum as a strawman, if nothing, to kind  
11 of inform what the next steps are in the  
12 framework. So we plan on running through  
13 these.

14 And so if I could get next slide?  
15 The first is emergency care. So we are  
16 defining emergency care as healthcare that is  
17 provided in an emergency department, emergency  
18 medical services system or acute care area of  
19 a hospital.

20 A further clarification around  
21 this is that emergency care refers to the  
22 treatment of high acuity or life-threatening



1 conditions in an expedited fashion recognizing  
2 that timely care of emergency patients may  
3 prevent morbidity or a significant -- excuse  
4 me, prevent mortality or significant  
5 morbidity.

6 The next term is regionalization.  
7 Regionalization refers to the concept of an  
8 established network of resources that deliver  
9 specific care, for example, protocols,  
10 definitive procedures, higher care levels or  
11 care pathways that is not universally  
12 available in the out-of-hospital setting.

13 For example, a physician's office  
14 or it's acute care hospitals.

15 Importantly, regionalized does not  
16 equal centralized care.

17 The third key term is system. A  
18 system or system of care is a coordinated  
19 chain of healthcare providers and associated  
20 infrastructure, including both in-hospital and  
21 out-of-hospital components, that delivers care  
22 to patients with specific emergent medical or

1 surgical needs.

2           Next slide. A system of care may  
3 exist to serve a particular geographical area,  
4 patient population or disease condition. The  
5 out-of-hospital component may be represented  
6 by the pre-hospital, for example, emergency  
7 medical services, recognition of a time-  
8 sensitive condition and initiation of a system  
9 of care or could also be represented by the  
10 transfer of a patient for definitive care  
11 within a regionalized network.

12           MR. COOPER: Chuck?

13           DR. CAIRNS: Yes?

14           MR. COOPER: Given your initial  
15 definition of emergency care, would a patient  
16 who is hospitalized in an acute care area of  
17 a hospital who suddenly develops an emergent  
18 condition, either related or unrelated to the  
19 reason they are in the hospital, would that  
20 count as part of this as well or you mean to  
21 focus only on care that is initiated outside  
22 the hospital?

1 DR. CAIRNS: Great question, Art.  
2 So I think that's something the group can  
3 decide on. Clearly, there are going to be  
4 cases where patients are going to be sent to  
5 a setting that does not have the specialized  
6 services they need and they could have a time-  
7 sensitive life-threatening condition that will  
8 require transfer and management in another  
9 facility.

10 So from the perspective of the  
11 eventual destination, that was an out-of-  
12 hospital transfer for an emergency care  
13 condition.

14 I would also understand the  
15 perspective of the episode of care started  
16 with the initial condition and then followed  
17 them through those different units to service.  
18 So I think it's something worth discussing.  
19 No, it's great.

20 MR. McCULLOUGH: One comment.

21 DR. CAIRNS: The other part of the  
22 -- you know, we are -- excuse me, I didn't

1 preface my remarks. I'm trying to make this  
2 as interactive as possible.

3 MR. McCULLOUGH: One comment  
4 regarding that. I know from the perspective  
5 of the American Heart Association, many of our  
6 courses, especially those in resuscitation,  
7 advanced life support for adults and for  
8 pediatric centers around both the out-of-  
9 hospital and in-hospital emergent event and  
10 how that is treated differently than what  
11 would be the reaching care provided on a  
12 medical order in a pediatric facility.

13 So I would not like to say that we  
14 exclude an emergency event, you know,  
15 particularly from the area of training and  
16 also in the concept of many facilities that  
17 have organized medical emergency response  
18 team, well, that is becoming a growing body of  
19 knowledge in and of itself of how to deal with  
20 those pre-arrest events and how to manage  
21 those again differently from reaching care  
22 measures.

1 CO-CHAIR ROSZAK: Chuck, do you  
2 want to go through these and then come back  
3 and relitigate them all or do you want to do  
4 it one at a time? What's your preference  
5 here?

6 DR. CAIRNS: Whatever works for  
7 the group, Andy.

8 CO-CHAIR ROSZAK: Okay.

9 DR. CAIRNS: I certainly could go  
10 through them. They are not extensive and then  
11 we could go back to key terms.

12 CO-CHAIR ROSZAK: Yes. Let's go  
13 ahead and get through them all and then we'll  
14 come back and relitigate the issues, if need  
15 be.

16 DR. CAIRNS: Fair enough. Did you  
17 say relitigate? Well, the good news is that  
18 I think the next slide starts the domains. So  
19 if you want to go back through the  
20 definitions, Andy, maybe this would be a good  
21 opportunity to do so.

22 CO-CHAIR ROSZAK: Yes, why don't

1 we go back to the first one. I believe the  
2 first one was emergency care?

3 DR. CAIRNS: Yes.

4 CO-CHAIR ROSZAK: Okay. So  
5 emergency care. Do we have comments around  
6 the table about the working definition? Oh,  
7 for God's sake, you're supposed to be up here.  
8 What are you doing?

9 CO-CHAIR KELLERMANN: I'm not  
10 chairing this session, so I get to act like  
11 that. Chuck, personally, I like the second  
12 paragraph a lot more than the first paragraph,  
13 because it's generic, rather than provider  
14 organized.

15 And the other limitation in my  
16 mind with the first paragraph is that you are  
17 leaving out another very important component  
18 which is the bystander and that's not just for  
19 cardiac arrest, it's for trauma and a lot of  
20 other things.

21 In particular, we talked about  
22 disasters and resilience. Community

1 engagement is going to be more and more  
2 important in systems of care. So I would back  
3 away from a provider focus and consider more  
4 the conditions for defining it. Because it  
5 starts with the next door neighbor, the family  
6 member, the witness.

7 CO-CHAIR ROSZAK: All right.

8 Rick?

9 DR. MARTINEZ: Yes. Just to  
10 further actually look not from the provider,  
11 but it's actually the location of care. And  
12 I think that is going to change dramatically,  
13 so we might limit ourselves as this thing  
14 grows in time, given the comments made by  
15 others. I do like the second paragraph quite  
16 a bit.

17 CO-CHAIR ROSZAK: All right.

18 Nick?

19 MR. NUDELL: Going back to  
20 something I said earlier, I think I do also  
21 like the second paragraph more, but I think it  
22 still also requires somebody to identify if an

1 emergency exists in order to know. And in the  
2 911 world, that really starts with dispatchers  
3 doing triage.

4 So they are not always thought of  
5 as being part of the healthcare system, but it  
6 starts very early in the process, or it could.

7 CO-CHAIR ROSZAK: Skip, do you  
8 have a comment? Your tent is still up there.

9 MR. KIRKWOOD: No.

10 CO-CHAIR ROSZAK: No? Okay.

11 John?

12 DR. FILDES: I am sure there is a  
13 way to reconcile it, but, for example, if the  
14 healthcare that is provided in the emergency  
15 department is say obstetrical or burn and it  
16 might be in a high acuity treatment area that  
17 is not exactly in the four walls of the  
18 emergency department, I'm sure there has got  
19 to be some way to reconcile that.

20 CO-CHAIR ROSZAK: Jesse?

21 DR. PINES: Just thinking about  
22 that second paragraph, I mean, you know, this



1 is, I guess, getting back to the initial  
2 comment that I made, what percentage of  
3 emergency department care really is  
4 encompassed in that second paragraph?

5 I mean, that's, you know, part of  
6 what we do, but that's not really the majority  
7 of what we do. So when we seek to define  
8 that, you know, particularly when it comes to  
9 regionalization, it may be helpful to broaden  
10 it a bit too. Just a thought.

11 CO-CHAIR ROSZAK: Go ahead, Rich.

12 DR. ZANE: I think there probably  
13 should be mentioned the episodic or  
14 unscheduled nature of the care as well.

15 MR. COOPER: Yes, that's a very  
16 good question. And I think we need a little  
17 bit more discussion by the group. Are we  
18 speaking about, you know, in effect fast-track  
19 care? Are we including that in our -- do we  
20 mean to include that in our definition of  
21 emergency care or not? I am not sure I know  
22 the answer to that question, but my guess is

1 that, you know, the greater public is probably  
2 more interested in the emergency component of  
3 it than the fast-track component of it.

4 I may be wrong, but I just raise  
5 the issue for discussion.

6 DR. MAIER: I mean, I agree. I  
7 think it is difficult and I think my personal  
8 bias is to stay more focused on the two  
9 emergency life-threatening high acuity, except  
10 that the rest of the patients in the emergency  
11 department have a great effect on the  
12 resources and availability and access of those  
13 high acuity patients.

14 So I think it's definitely a part  
15 of the process. Whether it is absolutely  
16 defined in this paragraph or definition maybe  
17 not, but I think they have to be a strong  
18 consideration of the system and how you  
19 monitor the systems effectiveness.

20 CO-CHAIR ROSZAK: I think that's a  
21 great point. That's going to be really key.  
22 Of course, people in the room understand that,

1 but as we expand this concept beyond people  
2 who are not, you know, familiar with the  
3 intimate details of what we do on a daily  
4 basis, it's important to capture that very  
5 sentiment.

6 Other comments? Tom?

7 MR. LOYACONO: Yes, just to follow  
8 that. I think the definition of emergency  
9 care would focus on the care and the point  
10 that is being raised about location would  
11 follow in the system or one of the other  
12 definitions.

13 If we decide to retain the first  
14 paragraph though, I think we need to identify  
15 what we mean by emergency medical services.  
16 Are we implying the three hospital care piece,  
17 because there are varying definitions that  
18 depending on who you are talking to, what it  
19 really means.

20 CO-CHAIR ROSZAK: Yes. And I know  
21 this was an issue that we struggled a little  
22 bit at the conference that, you know, Brendan

1 and Rick hosted not too long ago. Of course,  
2 the IOM struggled with this as well as many of  
3 you are intimately aware.

4 So, Chuck, Jeff, any comments on  
5 the definitions on the thoughts that we have  
6 heard?

7 DR. CAIRNS: One, I thought there  
8 was excellent discussion. And you know, when  
9 you think of a system of care and we take the  
10 episode of care model, it is easy to try to  
11 put these into frameworks of systems we could  
12 hold accountable.

13 But I think taking a step back and  
14 just looking at the second paragraph and  
15 saying this is what we want to define  
16 emergency care and then put that in the  
17 framework would open up, first of all, Phase  
18 1 for everything from preparedness as well as  
19 community engagement.

20 And then number two, would still  
21 allow us to have frameworks within units of  
22 service, including bystanders. So I think

1 this is a very robust discussion.

2 MR. WILLIAMS: I would just add  
3 one point. I agree with what Dr. Maier said  
4 regarding the bias maybe to stay on true  
5 emergency care. And the only thing I would  
6 add to that is the extent that the sort of  
7 urgent care components that Dr. Cooper  
8 mentioned, which are important, clearly,  
9 especially as they impact the care of acute  
10 patients may be less relevant to a  
11 regionalized system.

12 You know, you don't necessarily  
13 need regionalized ankle sprain care. And so  
14 for that reason, we had sort of focused more  
15 in our brains on the high acuity life-  
16 threatening side. But I think I agree it's a  
17 good discussion.

18 DR. PINES: Just to expand on  
19 that, I mean, when -- we have a word up there  
20 that says timely care. And most of the  
21 diseases we are talking about today, our time  
22 is measured in minutes. But time, you know,

1 could also be measured in days and weeks.

2 And Ron talked about the access  
3 issue. You know, to give a clinical example,  
4 someone comes in with chest pain who doesn't  
5 have an AMI, are we talking about  
6 regionalization for that individual? You  
7 know, that patient wouldn't be seen in the  
8 urgent care side.

9 And I agree that when we are  
10 talking about what -- we are not talking about  
11 ankle sprains here. We are talking about the  
12 most common thing -- complaints that people  
13 come into the emergency department with, which  
14 are chest pain and abdominal pain and a  
15 fraction of those actually have time-dependent  
16 diseases that are time-dependent on the order  
17 of minutes and hours and maybe even days.

18 So when we are thinking about a  
19 regionalized system, you know, I think it  
20 would be more helpful to broaden a little bit  
21 and think, you know, perhaps more complaint-  
22 based stuff, you know, for someone with chest

1 pain.

2 You know, the 2007 ACC Guidelines  
3 say chest pains should have a stress test  
4 within 72 hours. You know, is that the job of  
5 regionalized system to ensure that actually  
6 gets done, assuming that they don't show up  
7 with ST second elevations?

8 CO-CHAIR ROSZAK: So would you  
9 like to see the word timely removed? Is that  
10 your suggestion or what is your --

11 DR. PINES: I think we are talking  
12 about timely, but I think we might want to  
13 have a qualifier in there about exactly what  
14 we are talking about. You know, perhaps -- I  
15 would have to think about it exactly as to the  
16 wording, but I think the notion that timely  
17 care means, you know, from the patient  
18 perspective. Yet, getting access to, you  
19 know, the medical care that they need in a  
20 timely fashion from their perspective.

21 CO-CHAIR ROSZAK: Okay.

22 DR. PINES: And also from a

1 guideline perspective.

2 CO-CHAIR ROSZAK: John?

3 DR. FILDES: So the real question  
4 is do you want to capture the universe of  
5 patients who get their medical care in the  
6 emergency department or do you want to go in  
7 the direction of a disease-specific registry  
8 that is acuity-based? Because that sounds  
9 like where you are trying to go.

10 You're trying to go to if you are  
11 this sick or sicker, then we want to record  
12 you. But if you are less sick than that, we  
13 don't want to record you.

14 CO-CHAIR ROSZAK: Well, I  
15 certainly think those comments have been  
16 reflected before. I think there is definitely  
17 the people that are always going to be there  
18 no matter what, and I don't know what we can  
19 exactly qualify if they are there for  
20 emergency purposes or not, but they are still  
21 there, so we can't just discredit them.

22 But I am kind of inclined like



1 Jeff was saying there, are we really going to  
2 set up a system for toothaches and ankle  
3 sprains and this kind of stuff? Is that  
4 really the intent of regionalization?

5 So it is a little bit of a  
6 quandary and I appreciate everybody's input on  
7 that. Now is the time to speak up experts and  
8 let your voices be heard. With that, Dr.  
9 Carr?

10 DR. CARR: I actually think that  
11 we are describing -- I think emergency care  
12 captures a piece of this. It captures the  
13 piece that I think most of us in the room are  
14 talking about building regional systems  
15 around. I just think there is another term  
16 that isn't on here that is the broader picture  
17 of what gets done for unscheduled care.

18 So would it change things to add  
19 another definition to say, you know, to  
20 describe what acute care is or unscheduled  
21 care or something like that and to create a  
22 definition around that? And then to say that

1 a piece of that, 10 percent of it, I don't  
2 know if the number is -- Jesse is sort of  
3 asking somebody to put their neck out there  
4 and say what proportion of what we do.

5 Some smaller percentage of that is  
6 emergency care and is the piece that needs to  
7 be regionalized.

8 CO-CHAIR ROSZAK: That may, you  
9 know, play into some of the stuff that Skip  
10 and, of course, Gary have been talking about  
11 with their community, you know, EMS programs,  
12 community paramedics and all that kind of  
13 stuff would still be kind of captured in that  
14 second bucket of, you know, unscheduled care  
15 or maybe something that is not under this  
16 definition classified as emergent care, so  
17 that might be a good idea.

18 MR. McCULLOUGH: I think we have  
19 to define for ourselves whether we want to  
20 define emergency care what we would like for  
21 it to be or what it is now and most likely  
22 what it will continue to evolve to be in the

1 future.

2 Even within the same definition of  
3 EMS, truly we are an emergency medical  
4 service, but probably only about 10 to 15  
5 percent of what we do are the emergency  
6 components. The 80 percent is big MS, the  
7 medical services. So again, I think we should  
8 consider not just what we envision it to be or  
9 should be, but what in reality it is now that  
10 the community uses us.

11 CO-CHAIR ROSZAK: Chuck?

12 DR. CAIRNS: You know, it's  
13 interesting because we, obviously, took a  
14 functional approach as we put together our  
15 thoughts in the framework draft. And so I  
16 think that one thing is true is that this area  
17 has evolved rapidly.

18 As an example, discussing with Art  
19 Kellermann during the break, that at the NIH  
20 roundtable on medical and surgical  
21 emergencies, and by the way they took on the  
22 whole area. The first time we went with the

1 NIH Directors, Dr. Sohini said what is the  
2 hypothesis of -- for emergency care?

3 In other words, what is the basis  
4 for the field? We responded back saying that  
5 time makes a difference in people's lives.  
6 And we were able to find 14 conditions where  
7 time has proven to make a difference in terms  
8 of reducing mortality and that time is  
9 measured on the order of minutes to hours.

10 And so if you were to take one  
11 perspective of that status of the field, we  
12 say that time-sensitive mortality reducing  
13 conditions would be a focus of emergency care.

14 I would hope that the evidence  
15 will expand beyond those 14 conditions and I  
16 suspect that it will -- there will be a number  
17 of conditions once the systems are in place,  
18 they will also become targets for  
19 intervention.

20 So in that sense, clearly, the  
21 current status is a valuable construct. When  
22 we talk about what may move forward in the

1 future, just an observation, 50 percent of  
2 patients admitted to my hospital now come to  
3 the emergency department. That's up from 35  
4 percent 15 years ago.

5 So our role in the healthcare  
6 system -- emergency care's role in the  
7 healthcare system is clearly increasing. And  
8 to not recognize that evolution and challenge,  
9 I think would also be difficult.

10 So I gave you a split answer, but  
11 I do think one of the valuable things in this  
12 framework is for this group to define it.  
13 This is an opportunity to talk about how it  
14 will be defined for a population and  
15 geography.

16 CO-CHAIR ROSZAK: Go ahead, Jesse.

17 DR. PINES: I mean, I don't have,  
18 you know, any great great answers, but I guess  
19 one of the ways to think about it may be what  
20 patients that we see with -- you know,  
21 certainly the patients with MI and the really  
22 critically injured and a few other diseases

1 would benefit from regionalization?

2 But what patients do we see on a  
3 daily basis who would potentially benefit from  
4 regionalization? And it is probably not the  
5 dental pains and the ankle sprains, but it is  
6 -- it definitely goes beyond that type of  
7 condition that we are talking about.

8 So if we're thinking about, you  
9 know, regionalizing a system, I think taking  
10 it from a patient perspective and, you know,  
11 perhaps coming up with a set of conditions or,  
12 you know, expanding that list of 14 to things  
13 that, you know, we see commonly that could,  
14 you know, for the most part are taken care of  
15 by us, you know.

16 There are -- when you have chest  
17 pain, you don't, in general, go to urgent care  
18 centers and retail clinics. You know, that's  
19 what we take care of. We take care of  
20 abdominal pain. You know, looking at the top  
21 10 list of things that we see and thinking  
22 about from a complaint perspective, rather

1 than a disease perspective.

2 CO-CHAIR ROSZAK: Dr. Wright?

3 DR. WRIGHT: Where this thread of  
4 discussion -- particularly, Chuck's comments  
5 about the role of emergency care in the  
6 broader healthcare system is leading me is to  
7 suggest that if we don't consider the  
8 functional aspect of what emergency care is  
9 about in the context of the broader healthcare  
10 system, what we miss is the opportunity to  
11 really address the resource consumption that  
12 is at play.

13 When we want to deal with the  
14 time-sensitive and need to deal with time-  
15 sensitive conditions and have the other, I'm  
16 picking out a number right now, I'm not done,  
17 70 percent of what goes on or whatever, that  
18 consumes resources and perhaps impacts the  
19 time-sensitive delivery of care.

20 The other element of that that  
21 comes into play is that just like you, all of  
22 us are experiencing an increase in these

1 ambulatory care sensitive conditions in the  
2 department that if -- I think we have an  
3 obligation to contribute to the definition of  
4 not just the time-sensitive, but the non-time-  
5 sensitive things that don't need to be there  
6 and begin to suggest where they are best cared  
7 for, how they are best cared for.

8           And I think if we don't recognize  
9 that on the context of our discussion and our  
10 framework here, then we will not be informing  
11 the rest of the system as we should.

12           CO-CHAIR ROSZAK: Would your  
13 recommendation be to have -- create an  
14 additional definition then or would you like  
15 to see this one modified?

16           DR. WRIGHT: I think that a more  
17 expansive definition that does recognize the  
18 non-time-sensitive conditions that  
19 functionally do operate in the emergency care  
20 environment.

21           CO-CHAIR ROSZAK: Ron?

22           DR. MAIER: So I would like to



1       argue against that approach. To me, the  
2       concept I thought we were addressing is how do  
3       we deal with time-sensitive disease. Maybe  
4       that's not why we are here, but I thought  
5       that's why we were here.

6                   And it's more than just what  
7       happens in the emergency department. It's  
8       what happens. Do you have the operating rooms  
9       available? Do you have the ICU beds? Do you  
10      have the rehab? You know, do you have the  
11      access on the front end for time-sensitive  
12      diseases?

13                   Not that what is being discussed  
14      is not important. And the fact that if it  
15      keeps going the way it is, it may collapse the  
16      whole emergency regionalized system and that's  
17      why I say it needs to be a factor. It is a  
18      great risk factor to being able to deliver  
19      time-sensitive care.

20                   But to me, it should be brought in  
21      in that sort of construct that it is a major  
22      business of the emergency department, it has

1 a major potential negative impact on  
2 optimizing time-sensitive care, but what we  
3 are trying to do is look at a way to optimize  
4 development of the system to ideally deal with  
5 the time-sensitive diseases.

6 And bringing in these other things  
7 are going to be a negative impacts on that,  
8 but truly focus on that and the longitudinal  
9 aspect of it, which has never been done  
10 before. We have gotten stuck in the emergency  
11 department. What can the emergency department  
12 do for acute MIs?

13 What can the pre-hospital people  
14 do for acute MIs? And to me, this is the  
15 opportunity to look at it as a system approach  
16 to the disease, which is time-sensitive  
17 illness. And that has never been done. And  
18 to try and bring some standards of care to  
19 that process for multiple diseases.

20 CO-CHAIR ROSZAK: All right.

21 Let's go to Allen.

22 MR. McCULLOUGH: It sounds as if

1 we are just trying to define three concepts  
2 under the umbrella of emergency care. At  
3 least the three concepts I'm hearing is what  
4 is an emergency? What is emergency care? And  
5 then what are emergency services?

6 So perhaps we might need to, if we  
7 are really attempting to define those  
8 components, define those individually and not  
9 attempt to try to define that all-inclusively  
10 under one term.

11 CO-CHAIR ROSZAK: Rick?

12 DR. MARTINEZ: Going back to  
13 John's point earlier. I think, you know,  
14 every day under federal law, I have to  
15 determine whether an emergency medical  
16 conditions exists or not. And I do that very  
17 well, although I have no idea what that is.

18 Okay. I mean, it's true, right?  
19 It's very subjective. But it is interesting  
20 if you are going to measure the system and the  
21 system is required by federal law to deal with  
22 emergency medical conditions, we ought to

1 probably maybe add some light to what the  
2 definition is.

3 Is it time-sensitive? And I kind  
4 of think we are going along that line. I know  
5 Dr. Carr has done some great work along those  
6 lines, but that may be one of the benefits  
7 coming out of this.

8 DR. CAIRNS: Yes. In fact, I was  
9 just going to refer to Dr. Carr, because you  
10 took on this issue along with Dr. Clancy, the  
11 Director of the AHRQ.

12 DR. CARR: Is that okay?

13 CO-CHAIR ROSZAK: Yes.

14 DR. CARR: I'm sorry. It's nice  
15 of these guys. I was looking it up to make  
16 sure I got the words right while they are  
17 throwing me under the bus. So we wrote a  
18 paper describing an emergency care sensitive  
19 condition, which I think -- which we wrote  
20 with Dr. Clancy because the universe of  
21 ambulatory care sensitive conditions are  
22 known, make sense to folks and we just sort of

1 said there must be this parallel universe of  
2 conditions that emergency care makes an impact  
3 upon.

4 And so I guess I think that we are  
5 saying or that most of the table is saying  
6 yes, emergency care is very broad and probably  
7 we shouldn't regionalize at all. What is the  
8 subset that we want to regionalize? And I  
9 guess I would argue that the emergency care  
10 sensitive condition, the analog, the  
11 ambulatory sensitive care condition is that  
12 which we might want to regionalize.

13 And I promise you, I will read the  
14 definition if I could find it. So ambulatory  
15 care sensitive conditions are conditions for  
16 which good outpatient care can potentially  
17 prevent the need for hospitalization for which  
18 early intervention can prevent complications  
19 or more severe disease.

20 All right. Those are exist -- and  
21 those exist and we know what those are. And  
22 emergency care sensitive conditions, I still

1 can't find.

2 CO-CHAIR ROSZAK: I got it.

3 DR. CARR: I want to get the words  
4 right.

5 CO-CHAIR KELLERMANN: We can come  
6 back to you.

7 DR. CARR: Thank you, sir.

8 CO-CHAIR ROSZAK: Gary, go ahead.

9 MR. WINGROVE: I am going to  
10 switch to someone earlier said we should  
11 define what emergency medical services is.  
12 And in the last 12 months or so a term has  
13 kind of cropped up out here that has been  
14 fairly widespread adopted to describe those  
15 parts of EMS that aren't the hospital and it  
16 is field EMS.

17 That would not include the 911  
18 centers. So if we are going to talk about the  
19 911 center, we need to include it specifically  
20 as well. But at the time this paper was  
21 written, that term probably wasn't out here,  
22 but it is widespread now and maybe that's a

1 better term to use in the definition.

2 DR. CARR: Yes, sorry about that.

3 So emergency care sensitive conditions would  
4 then be described as "Conditions for which  
5 rapid diagnosis and early intervention in  
6 acute illness or acutely decompensated chronic  
7 illness improve patient outcomes.

8 DR. PINES: So just to make that a  
9 little broader, I mean, where we are talking  
10 about, you know, I think those conditions and  
11 people with symptoms of those conditions. I  
12 mean, I think that's where the differentiation  
13 is between the ankle sprains and the chest  
14 pain is that, you know, if we just add, you  
15 know, potentially high acuity and life-  
16 threatening conditions, I think that would be  
17 more reflective of what we do.

18 CO-CHAIR ROSZAK: John?

19 DR. FILDES: I just thought I  
20 might add something for the discussion. I  
21 hold up National Burn Repository and, of  
22 course, National Trauma Databank. So to get

1 into the National Burn Repository, you have to  
2 first have a diagnosis of a burn.

3 You either have to die, be  
4 admitted or be transferred out to a hospital  
5 that can take care of you. That's the only  
6 way you can get into that repository. And it  
7 represents about 90 percent of burn centers in  
8 the United States.

9 And then in the National Trauma  
10 Databank, you have to have an ICD-9 Injury  
11 Code. You have to die, be admitted or be  
12 transferred up to a level of care, and that  
13 has about 90 percent reporting from Level 1s  
14 and 2s in the United States.

15 So it's a matter of diagnosis,  
16 geography and outcome that qualify you for  
17 that disease-specific registry for both burns  
18 and for trauma.

19 CO-CHAIR KELLERMANN: Weighing in  
20 on this, I have come down on the grade that  
21 favors focusing on very high acuity conditions  
22 and symptoms, because that's really where the



1 time criticality piece of this comes in.

2 I do believe that everyone else  
3 profoundly affects how well the system can, in  
4 fact, deliver on that. And thinking back to  
5 the pre-lunch admonition that we look for  
6 common things across conditions before we go  
7 into conditions, it seems to me in a sense,  
8 for lack of better terms, we are talking about  
9 measures of capability, capacity and staffing  
10 across multiple conditions.

11 Capability is kind of what we do  
12 when we designate various centers now -- often  
13 deals with stuff, but it can also deal with  
14 expertise, etcetera. Capacity is when we are  
15 swamped or on diversion or overloaded or out  
16 of ambulances or no 911 operators available.

17 Staffing is clearly an issue Dr.  
18 Kusske was getting to with on-call specialist  
19 coverage, etcetera, and systems that manage  
20 that may be better positioned to do that than  
21 otherwise. All of those are, if you will,  
22 structure measures using the Donadedian

1 quality of care metric.

2 Then there is going to be a whole  
3 other set of metrics on performance, which is  
4 the process part of quality. And then  
5 outcomes and costs. And it seems to me if we  
6 keep that in mind as an overall -- capability,  
7 capacity, staffing, performance, outcomes and  
8 costs -- that we've got, we are a long way  
9 towards where we want to go, but with a focus  
10 on high acuity conditions, time-critical  
11 conditions.

12 CO-CHAIR ROSZAK: Let's go to  
13 John.

14 DR. KUSSKE: Just real quick.  
15 Well, when I first read this, all this  
16 material, I immediately thought of time-  
17 sensitive conditions, because that's all we  
18 deal with primarily. And I thought that we  
19 were going to be talking about regionalizing  
20 those conditions like neurosurgical problems,  
21 which do require personal expertise, staff,  
22 facilities, a whole host of things to make it

1 work right.

2 And just having a neurosurgeon on  
3 call doesn't make it a specialized capability.  
4 There are a lot of other things that are  
5 needed. And it seems to me that that is going  
6 to require a system that has identified  
7 facilities that can do that, and that seems to  
8 me to be part of the regionalization.

9 And some of the other things that  
10 have been talked about, I mean, it's the same  
11 way. A 16 year-old with an epidural with a  
12 dilated pupil has got about an hour to live  
13 before they herniate and die. So they are  
14 time-sensitive and need to be done.

15 So that's where I'm coming from.  
16 And I recognize that setting up systems that  
17 are going to accommodate that may be difficult  
18 in various parts of the country, because of  
19 the distance and a number of other factors,  
20 but that's how I came into this system,  
21 thinking we are going to be talking just about  
22 time-sensitive care.

1 CO-CHAIR ROSZAK: All right. For  
2 the purpose of time management, we are going  
3 to have to wrap this discussion up pretty  
4 quickly. We have a few more definitions and  
5 a few other things to get to. So, Chuck, I'll  
6 let you ask some last -- I think there is --  
7 it's pretty safe to say some general agreement  
8 at least about what we are talking about here.  
9 People are shaking their heads, yes -- ?

10 Some people are not shaking their  
11 heads, yes. I think it's pretty safe to say  
12 that we have a general idea and I think we  
13 kind of share the general idea of what we are  
14 talking about when we are talking about  
15 regionalizing services. It seems to me  
16 everyone has kind of expressed that in similar  
17 terms. So we will certainly, you know, be  
18 able to redraft some definition that is more--  
19 Helen, you want to jump in here? Go ahead.

20 DR. BURSTIN: Just one, again, a  
21 context piece. I think it is fine to define  
22 emergency care and I think you are kind of

1 coming towards that. There is lots of other  
2 opportunities in a framework, though, beyond  
3 definitions.

4 So what it sounds like you are  
5 talking about is -- it sounds like there is  
6 probably a very important domain of sort of  
7 contextual issues around primary care access,  
8 ambulatory care, sensitive conditions that are  
9 going to be important to measure for people to  
10 really be able to understand the effect of  
11 regionalized emergency care.

12 But it doesn't have to be part of  
13 your definition of emergency care, but it  
14 might be a very important arm of your domain  
15 or sub-domain.

16 DR. CAIRNS: Helen, I just wanted  
17 to say: well put. I mean, the reason to go  
18 through these key terms and definitions --

19 CO-CHAIR ROSZAK: All right.

20 DR. CAIRNS: I'm done.

21 DR. MAIER: Well done, period.

22 DR. CAIRNS: But I get the

1 microphone again, Ron.

2 CO-CHAIR ROSZAK: All right.

3 Let's go to the next one, and we will keep  
4 chugging away here.

5 DR. CAIRNS: So the next  
6 definition regionalization. This was taken  
7 from, you know, many reports. I see Ron has  
8 already got his tent up, so go ahead and fire  
9 the first shot if you will, sir.

10 DR. MAIER: I think this is  
11 actually a very good definition. The problem  
12 I had is then you read the next one and, to  
13 me, you use different words to say exactly the  
14 same thing. And I guess that's why I just  
15 bring up the lock -- to sort of lump them both  
16 together. I think they are saying exactly the  
17 same thing.

18 And the question gets back to --  
19 do we need to spend a lot of time  
20 disassociating them, or just recognize that  
21 they are integral parts of each other. Since  
22 you call this -- actually, I guess the next

1 one you use the word -- yes, it's regionalized  
2 system.

3 Then the next word is system. So,  
4 you know, there is total overlap. So I would  
5 just bring that up as a first point of  
6 discussion, as to whether these two -- we need  
7 to spend an hour trying to disassociate these  
8 two concepts as pertinent to our goal.

9 DR. CAIRNS: No.

10 (Laughter.)

11 CO-CHAIR ROSZAK: All right. Any  
12 other comments on the working regionalization  
13 definition, as it appears on the board? No?  
14 We're all happy with that? Okay. Let's go to  
15 the next one then.

16 System. So I guess -- kind of  
17 building on what Ron was saying -- is there a  
18 need to have this term defined? Is it  
19 integral to this process?

20 DR. MAIER: As I say, I couldn't  
21 tell any difference between the two, unless  
22 what you are trying to do is say that region

1 is part of a system or something that way.  
2 But I really couldn't, just reading the words,  
3 prove that from the verbiage, and I didn't  
4 know whether it was important to say that  
5 regionalized care becomes part of a larger  
6 system of care, in which case if you -- you  
7 know, if that's the important point, take home  
8 point, I guess we could wordsmith it.

9 But just from what is written up  
10 there now, I don't get that from it.

11 DR. CAIRNS: So fair enough, Ron.  
12 I think the reason that they were separate is  
13 just to have a discussion around this term  
14 regionalization. It means many things -- or  
15 it used to mean many things to many people,  
16 and frequently they didn't intersect.

17 I think when you start putting in  
18 the context of a system, you begin realizing  
19 how they would intersect, both in terms of  
20 geographies, populations, resources -- and  
21 certainly any framework of a discussion of  
22 performance, metrics, quality measures, and



1 everything else.

2 So I agree that systems kind of  
3 unifies a lot of the definitions of  
4 regionalization, and one of the key concept  
5 discussions we had was on this emergency care.  
6 And once you tackle that with regionalization,  
7 I think the system is inherent.

8 MR. McCULLOUGH: I would just  
9 recommend if we maintain that word in the  
10 definition of system, we may want to broaden  
11 it beyond again just the healthcare providers  
12 to include first responders, the public safety  
13 community, and certainly just community-at-  
14 large, since really that is where EMS systems  
15 begin -- is at the community level, so the  
16 word inclusive.

17 CO-CHAIR ROSZAK: Well noted.  
18 Rick?

19 DR. MARTINEZ: Yes, the only --  
20 and my little two bits on this is that -- I  
21 really hate the word regionalization. And the  
22 reason why I do -- I agree with it in many

1 ways. Like, I hate patient satisfaction, but  
2 I love patient-centered care, because one is  
3 measuring after the fact. You know, if I  
4 design it right, they are right in front of  
5 me. That's probably a better way to approach  
6 it.

7 But if you look at that  
8 conference, it was actually called "Beyond  
9 Regionalization: Building Integrated Networks  
10 of Care." And I don't know what the answer is  
11 on this, Chuck, but, you know, the reason we  
12 got that way is that a lot of people believe  
13 regionalization is all top-down.

14 Remember when we kind of started  
15 saying, we've got to do things differently as  
16 well, but who is going to run this thing? If  
17 you look at what is happening in the  
18 marketplace, people are aggregating together  
19 to build these networks, with or without us.

20 And so I don't have a right  
21 answer, but somewhere along the lines I just  
22 want to raise the question again. We do want

1 to make sure we are not using old terms that  
2 people believe in, and stopping innovative  
3 approaches that have to occur down the road.  
4 That's all.

5 DR. CAIRNS: I think it's a very  
6 fair comment and, frankly, some of our initial  
7 discussions with NQF and our partners were a  
8 rather pointed one about using the word  
9 regionalization.

10 The mechanical answer was: that's  
11 what the RFP was. I'm the departmental chair,  
12 I have to be a little bit practical when it  
13 comes to these things.

14 But secondly, it did provide a  
15 really broad discussion of those issues. So  
16 again, I think this is an opportunity in this  
17 framework paper for us to define those. And  
18 I think the regionalization conference SAM put  
19 together -- I think the IOM workshop -- really  
20 helped put these issues into a broader context  
21 than they historically have been used.

22 And so now, it's the case of,

1 again, making it functional.

2 CO-CHAIR KELLERMANN: I think what  
3 we have is fine, but you have to have some  
4 definition for a population. You can't  
5 measure quality without rates and you can't  
6 measure rate without a denominator. And if  
7 you think back, Chuck, even to your original  
8 figures, those little funnel graphs, that  
9 first funnel was population at risk.

10 So somewhere in the definition,  
11 system could be a system for one person or a  
12 system for 300 million people, but what's the  
13 population? It may not be geographic, but I  
14 do think there needs to be some term in there  
15 that references that this is a population-  
16 based concept. Otherwise, we can't really, as  
17 Mike Rapp said this morning, measure care  
18 across systems -- otherwise.

19 DR. CAIRNS: Art, I would just  
20 like -- one, I agree with you. In fact, it  
21 harkens back to some of the earlier work done  
22 on emergency care and regionalization, in the

1 sense of defining a population within a  
2 specified geography.

3           It was one of the old terms we  
4 used to use, because whether we like it or  
5 not, Rick, I mean, a lot of these things are  
6 defined by geographical distributions, whether  
7 that is by a state -- by a county, for  
8 example, in terms of EMS -- or in terms of  
9 accountability, at least in our current  
10 system.

11           So defining that as an inclusive  
12 population within a specified geography would  
13 be one approach.

14           CO-CHAIR KELLERMANN: Yes. I  
15 mean, I just think whatever it needs to be for  
16 a defined population, because it could be  
17 geographical, but it could be the subscribers  
18 in your system. I think back to the IOM  
19 Regionalization Conference and Dave Magid's  
20 carrying on about how Kaiser patients were  
21 better going to their Kaiser hospitals, or to  
22 the nearest hospital, or whatever.

1           So I just think we can keep it  
2           open, but there needs to be the concept, the  
3           population-at-risk embedded in it.

4           DR. CAIRNS: Yes, I mean, that's  
5           fair enough. I think what the challenge is,  
6           when you get into ACOs and we get into Kaiser  
7           and other models, is the intersection with the  
8           EMS. It's just one of those things that I  
9           consider challenging.

10           It's interesting how electronic  
11           healthcare records are definitely leading to  
12           development of ACOs and concepts across those  
13           care settings for a defined population. But  
14           how EMS, which is caring for that population  
15           at this initial episode, has not been  
16           integrated.

17           And I think that is just being --  
18           one of the challenges that I find when we  
19           select populations based on, say, an ACO  
20           model. But that's just for the group to  
21           discuss.

22           CO-CHAIR ROSZAK: John?

1 DR. FILDES: To me, one of the key  
2 differences between regionalization and a  
3 system is that a system implies that you have  
4 got a plan, you have authority, and that you  
5 have someone who is managing the operations of  
6 the system.

7 And that's a lot different from  
8 regionalization, which can occur if somebody  
9 builds a cath lab and sends out an  
10 announcement to everyone, or if there is only  
11 one neurosurgeon in three counties, or if  
12 there is only one obstetrician on call at one  
13 hospital. Things will regionalize themselves,  
14 based upon resource and market forces and all  
15 sorts of things that don't require any  
16 planning or any action -- they just happen.

17 Systems require planning and  
18 action.

19 DR. WRIGHT: So you are in the  
20 camp of keeping this definition in, I'm  
21 guessing?

22 DR. CAIRNS: That was for context,

1 Dr. Maier. You notice that Dr. Williams also  
2 put the word in there for now.

3 CO-CHAIR ROSZAK: Use your mike,  
4 please, if you're going to talk.

5 DR. MAIER: But I think it does  
6 help deal with that very valid concern of the  
7 system being a plan, as opposed to the random  
8 nature of the marketplace -- is it does bring  
9 both parts together based on the traditional  
10 regional approach, but applying an overview  
11 system to make sure that it works as well as  
12 possible.

13 And you could also just put: as a  
14 population-based system or regionalized  
15 system. And then you would have your true  
16 denominator that you need.

17 CO-CHAIR ROSZAK: Arthur?

18 MR. COOPER: I did hear a few  
19 moments ago the issues of, shall we say,  
20 systems of care designed around payer groups.  
21 And so accountable care organizations, Kaiser,  
22 etcetera, etcetera, etcetera, at the risk of



1       stating the obvious, we are here at a meeting  
2       of the National Quality Forum at the National  
3       Value Forum, and I think our first task is to  
4       define the quality elements and leave the  
5       economic side of it for the moment.

6               I think there is no question that  
7       efficiency is vitally important, but I think  
8       the quality step comes first.

9               CO-CHAIR ROSZAK: All right. It  
10       looks like we have exhausted -- oh, I'm sorry,  
11       go ahead, Tom.

12              MR. LOYACONO: Yes, I just want to  
13       say, to me, the regionalized implies some  
14       geographic boundary. Do you have systems of  
15       care that define clinical care outcomes? The  
16       things that you have to do? But the  
17       regionalized piece says some geographic  
18       boundary.

19              And you can have small ones and  
20       big ones, and the regionalized system of  
21       trauma care in my community is not the same  
22       boundaries as the regionalized system of

1 cardiac care, but they interlock.

2 And I think that if we don't keep  
3 -- it goes to Dr. Kellermann's part on  
4 population, I think you have to measure it in  
5 terms of geography, or else you're not going  
6 to be able to measure it and it's not going to  
7 be meaningful. Just my opinion.

8 CO-CHAIR ROSZAK: All right. Very  
9 good. Any other pressing issues with the word  
10 system, the definition? Skip?

11 MR. KIRKWOOD: Just I think what  
12 I'm hearing is -- folks are comfortable with  
13 the concept of regionalized care. They are  
14 comfortable with the concept of systems of  
15 care. But not quite so with regionalized  
16 systems of care.

17 They may not be the same and they  
18 may be overlapping in different ways.

19 CO-CHAIR ROSZAK: Yes. That's  
20 kind of what I've heard, too, yes.

21 MR. KIRKWOOD: So we could  
22 carefully define something that simply doesn't

1 exist.

2 CO-CHAIR ROSZAK: Right. Which --  
3 and the overlap or the, you know, potential  
4 areas of difference between the two kind of  
5 leads me to wonder if we need both of these to  
6 stay in.

7 DR. CAIRNS: Andy, just from our  
8 perspective, and for your consideration, the  
9 reason to discuss these terms and definitions  
10 was to just help inform the framework.

11 CO-CHAIR ROSZAK: Right.

12 DR. CAIRNS: And so I agree with  
13 Helen's earlier comment that that's the value  
14 of this session -- is just so we can get some  
15 conceptual pieces out there, so we can now  
16 kind of build the framework, whether it is  
17 across the system or across disease  
18 conditions.

19 CO-CHAIR ROSZAK: All right.  
20 Let's move to the next definition. We will  
21 come back to this after we've had some more  
22 discussions later on today. We may very well

1 agree that we need to keep both of these, or  
2 maybe we can axe one of them.

3 So we had regionalization. We had  
4 system. Now, we have system of care? Okay.

5 DR. CAIRNS: Yes, it just modifies  
6 system, and -- Oh, I'll leave it up to you if  
7 it's valuable to go through this.

8 MR. WILLIAMS: One comment I would  
9 have -- and not to put Mr. Wingrove back on  
10 the spot -- but this might be an opportunity  
11 to further define the out-of-hospital  
12 component, if you wouldn't mind just repeating  
13 your comment about -- I believe you said  
14 earlier that there would be perhaps a better  
15 term that you would use to define emergency  
16 medical services. And I didn't catch all of  
17 that.

18 If you could just repeat that?  
19 This might be an opportunity to further define  
20 the out-of-hospital piece.

21 MR. WINGROVE: Yes. About a year  
22 ago, the term field EMS started to get used

1 around D.C. here. And it was set up to  
2 describe those parts of the EMS system which  
3 aren't the hospital, but are done out in the  
4 field and not in a fixed location.

5 It has gained a lot of popularity  
6 in the last 12 months, and is used in a wide  
7 variety of forums, and might be a good term to  
8 use here. I'm not sure it is intended to  
9 include the 911 centers, so we might want to  
10 be specific about that in the places where we  
11 want to talk about the 911 center.

12 But field EMS is pretty much the  
13 term of choice when talking about the parts  
14 that aren't the hospital.

15 CO-CHAIR ROSZAK: I guess looking  
16 at the definitions, I guess, I was just  
17 chatting with Art, my concern is that we are  
18 going to complicate or confuse people right  
19 off the bat, looking at these definitions, in  
20 an area that is somewhat already confusing if  
21 you are not familiar with the subject matter.

22 So a little bit for the sake of

1       brevity, it may be worthwhile to maybe combine  
2       one or two of these definitions into one. Any  
3       thought that you may have on that, Gary?

4               MR. WINGROVE: Personally, I like  
5       having them separated for this reason. When  
6       I first heard the term regionalization among  
7       emergency medical care, the first thing that  
8       popped into my head was: finally somebody is  
9       going to talk about having ambulance companies  
10      that serve a broad geography instead of having  
11      50 ambulance companies in that same geography.

12              So, for me, I wasn't quite sure  
13      what regionalized emergency care was trying to  
14      get at, but that's what it meant to me  
15      personally when I first heard it.

16              Seeing this definition on paper  
17      cleared that up for me. And that's why I  
18      think it is important, because my whole  
19      concept was: we are bringing things together  
20      in a tight network, and I get the distinction  
21      now by seeing the terms separated here.

22              CO-CHAIR KELLERMANN: I hate

1 wordsmithing, and I haven't had this much fun  
2 since I was on the Board of the American  
3 College of Emergency Physicians. But  
4 regionalized systems of care, regionalized  
5 seems to be in that where we ought to be  
6 talking about defined populations,  
7 geographically or otherwise.

8 Systems to me at least seem to be  
9 pre-thought, planned, organized methods of  
10 delivering services, etcetera, as we talked  
11 about not the one off or the -- I'm flying by  
12 the seat of my pants, but we thought it  
13 through.

14 And care is clinical services  
15 delivered by whomever to help improve  
16 somebody's outcomes.

17 Somehow when I look at these  
18 definitions, they are not lining up with that  
19 basic kind of syntax -- I mean, systems. We  
20 have systems of care definition here and we  
21 are describing populations.

22 And then regionalized, we talked

1 about how we are carrying forward the not --  
2 the populations themselves. So somehow if we  
3 get back to regional systems of care, and then  
4 you've got your taxonomy.

5 DR. CAIRNS: All fair points, Art,  
6 and I think the key thing is -- we are trying  
7 to put them in context for a discussion of the  
8 regionalized emergency medical services  
9 discussion. That was the reason to try to put  
10 some context, because they are -- whether we  
11 like it or not, there have been preexisting  
12 definitions and concerns regarding all these  
13 things.

14 And I would say, in particular,  
15 regionalization. And we got a lot of  
16 feedback, including some from our federal  
17 partners, that this would be one of our  
18 biggest challenges -- for us to hit this  
19 definition -- so we thought it was important  
20 to bring it forward.

21 CO-CHAIR ROSZAK: All right.  
22 What's the next slide? Okay. Whew.



1 DR. CAIRNS: Domains.

2 CO-CHAIR ROSZAK: I thought it  
3 might be like care or something. I wasn't  
4 sure, geography or --

5 DR. CAIRNS: Et tu, Andy.

6 CO-CHAIR ROSZAK: Right. So we  
7 are still being mindful of the time, so we  
8 would like to get through the domains and also  
9 the phases, and I know over lunch a lot of us  
10 chit-chatted about the episode-of-care  
11 framework that was laid out in the last  
12 session.

13 And, you know, really coming in  
14 here today, what I conceptually visualize as  
15 the episode-of-care, particularly the Phase 1,  
16 was not at all what we talked about. And it  
17 was a very expansive view of Phase 1 from what  
18 I had envisioned.

19 And, you know, I know there is a  
20 lot of concerns about that episode-of-care and  
21 trying to take what we are doing and make it  
22 fit. So I think we -- it is worthwhile to

1 have a little bit of discussion, probably at  
2 some point before we adjourn this session,  
3 about the different phases and where these  
4 domains could potentially fit or how they  
5 interact.

6           You know, one of the things that  
7 was a concern was that the episode-of-care  
8 almost by necessity is seemingly measuring one  
9 of the most expensive parts of the whole  
10 healthcare system, because you have an  
11 episode-of-care, someone needs treatment,  
12 automatically right off the bat you are  
13 generating costs.

14           And, you know, the challenge to  
15 capture the things that we are doing on an  
16 everyday basis, and, yes, I'm looking at you,  
17 Gary, because of the community paramedicine  
18 stuff and the prevention that, you know, you  
19 guys have been so successful at rolling out  
20 and doing. You know, we need to somehow  
21 capture that as value-added as well,  
22 especially if we ever want to get paid or

1 reimbursed for any of that prevention or, you  
2 know, preventing readmissions and all that  
3 stuff.

4           It needs to be measurable. It  
5 needs to be in the framework somewhere. So I  
6 think at some point we need to just talk about  
7 the different phases, and maybe they are more  
8 expansive than we initially thought. And we  
9 can certainly help flesh it out, and it's  
10 going to be an important part of moving  
11 forward, especially for tomorrow.

12           But I think for right now, we are  
13 going to -- let's get into the domains and at  
14 least try to get those working definitions  
15 down. Clearly, we have a little bit of work  
16 to do on the definition section we just went  
17 through, and I'm confident that with all the  
18 brain power in the room, we'll be able to have  
19 something that we can at least glance at by  
20 the end of the day or midday tomorrow, to try  
21 to revisit and just see if we've captured  
22 everybody's comments and thoughts.

1           So, Chuck, why don't we move on to  
2 the domains, and we will -- I believe we have  
3 definitions for each of these as well, right?

4           DR. CAIRNS: We just have a little  
5 clarification on what we are talking about.  
6 Again, these are all, by the way, in the draft  
7 report, if people want to see the context for  
8 them.

9           So the domains are detection and  
10 identification.

11           Next slide. Resource utilization;  
12 medical care; coordination of care; outcomes.

13           So we will start with the first  
14 domain.

15           Next slide. The main one,  
16 detection or identification. So, essentially,  
17 measuring regionalized emergency medical care  
18 services is the evaluation of how an episode-  
19 of-care is recognized as it begins. Emergency  
20 care is defined in part by time-sensitivity.  
21 Therefore, the measurement of the rapidity of  
22 detection and timely identification of the

1 nature of an emergency clinical episode begins  
2 the process of scrutinizing an episode of  
3 emergency care.

4 Domain 2 -- and remember, the  
5 wording on this is so that it fits on the  
6 slides. The text, I think, is better in the  
7 document.

8 Domain 2, resource utilization.  
9 At its most basic level, the concept of  
10 regionalization is about matching resources to  
11 patients. This domain evaluates the  
12 structural and process components of  
13 regionalized emergency medical care that  
14 catalog personnel, facility and service  
15 resources, and evaluate the use of those  
16 resources.

17 Domain 3, medical care. This  
18 domain -- divided into three sub-domains that  
19 identify where regionalized emergency medical  
20 care takes place -- evaluates the actual  
21 medical care to patients within an episode-of-  
22 care.

1                   The basic question being addressed  
2           is: did the patient receive medical care that  
3           met accepted standards? And this includes an  
4           evaluation of whether or not a patient in an  
5           episode-of-care received care that was timely  
6           and in accordance with broadly accepted  
7           standards and protocols for a given emergency  
8           medical condition.

9                   Domain 4, coordination of care.

10          This domain evaluates the connections between  
11          the various units of service within an  
12          episode-of-care. Regionalized emergency  
13          medical care services are comprised of many  
14          discrete components that must interact  
15          efficiently and effectively to achieve the  
16          best outcome for the patient.

17                  Domain 5, outcomes. Measuring  
18          patient-oriented outcomes of an episode-of-  
19          care may be the most pragmatic method of  
20          evaluating the effectiveness of a system.

21          While measuring structure and process elements  
22          are key to evaluating a system's functioning

1 parts, the end result -- the outcome of an  
2 episode-of-care -- may be the most obvious  
3 illustration of whether the system works.

4 I'm just going to reference Dr.  
5 Kellermann's suggestion on return of  
6 spontaneous circulation from cardiac arrest.

7 So those are the five domains.

8 CO-CHAIR ROSZAK: So the point of  
9 these domains or buckets or whatever  
10 terminology you want to call them is that when  
11 we are looking at a system, the regionalized  
12 system of care, these are the domains that we  
13 would necessarily want to look at to determine  
14 whether or not, you know, we are getting the  
15 quality, if the system is functioning  
16 properly, and all that kind of stuff.

17 So these are the, you know, put  
18 forth domains that we are going to be  
19 discussing, but I would like your take on  
20 them. If there is anything that you think  
21 that we are missing, if there is anything that  
22 is maybe too duplicative or if there is

1 anything that just doesn't make sense, Ron, as  
2 usual -- go ahead. Sally, do you want to jump  
3 in?

4 MS. TURBYVILLE: Yes. Just to add  
5 quickly to Andy's point -- and then tomorrow  
6 we will break up in work groups and further  
7 dive into this whole idea. So we are  
8 definitely -- in addition to the time today --  
9 we will revisit, because we realize how  
10 important it is to get these domains and sub-  
11 domains at a point that we can move the  
12 framework forward.

13 DR. MAIER: I want to support -- I  
14 think the domains, in general, are very  
15 appropriate and are the buckets so we can  
16 assess the system. The two again -- the  
17 flogging of my pet horse today, I'm not sure  
18 why I didn't come in planning on this -- but  
19 I take it within detection -- and it sort of  
20 gets back to Art's hang-up on population-based  
21 employment -- is the access.

22 Because, you know, again, if half



1 the people die before the 911 operator  
2 answers, you know, those who they do find may  
3 do well. But if half die unnecessarily before  
4 they get access into the system, there is a  
5 problem with the system.

6 And so I would assume that is in  
7 there, but just to emphasize that not knowing  
8 who is dying out there is not good.

9 And then the second half is --  
10 just for discussion. I don't know how far we  
11 want to go into recovery with this process,  
12 because, again, that's a major part of a good  
13 system -- is, you're not only avoiding the  
14 mortality and morbidity, but you are  
15 reintegrating those people back into society,  
16 at the optimal level of function.

17 And again, that may be more than  
18 we want to chew off in this session, but just  
19 it's a critical part of the system's outcome.

20 CO-CHAIR ROSZAK: Gary?

21 MR. WINGROVE: I am wondering  
22 whether two things are already built in here,

1 or not. That would be: is prevention an  
2 appropriate thing to have in here? And the  
3 other would be along the lines of what Dr.  
4 Maier just said, in terms of readmission or  
5 the end result, the final end result.

6 DR. CAIRNS: So excellent  
7 comments. Thank you again. So on the first  
8 one, I think that Phase 1 should certainly  
9 incorporate those issues, Ron. I think that  
10 we need -- I think that's a critical component  
11 of Phase 1 that we need to get into play,  
12 including access.

13 And then number two, I think this  
14 idea of outcomes is what we should define as  
15 kind of a measure of Phase 2 and Phase 3. And  
16 I think we need to figure that out. I think  
17 we need to define what is important.

18 Prevention, Phase 3. I think we  
19 are trying to look for a link for where  
20 regionalization of emergency care services  
21 should link with prevention. In a typical  
22 episode-of-care model from NQF, it would be

1 Phase 1.

2 I think the challenge that we face  
3 though is that we have people who intersect  
4 with us per our earlier definitions with an  
5 event. And so when you look at an event-based  
6 approach to this, I think there is a component  
7 for prevention and intervention in Phase 3,  
8 but I just bring that out as my interpretation  
9 of the episode-of-care.

10 And I don't know if there are  
11 other interpretations of how one might  
12 incorporate it into the traditional position  
13 of Phase 1.

14 CO-CHAIR ROSZAK: Other comments  
15 about the domain structure overall? Jesse?

16 DR. PINES: Just a point of  
17 clarification. Are these intended so each of  
18 the measures would fit uniquely into one of  
19 these domains? Because it seems like these  
20 are all really overlapping.

21 MR. WILLIAMS: Yes, I will field  
22 that. Yes, I agree. I think that's part of

1 the point. The domains, first of all -- and  
2 I appreciate the group's feedback -- are  
3 essentially just titles that we came up with  
4 that were, we felt, like some reasonable  
5 categorization of where measures could occur.

6 I think issues like access issues,  
7 like prevention issues that are coming up,  
8 that would be more specific to a certain  
9 measure, could certainly go in whichever  
10 domain seems most relevant to that measure.

11 And I agree with Chuck.  
12 Unfortunately, the slides don't do the sort of  
13 thought process justice. But within the  
14 draft, and specifically within our appendix  
15 where we go through the MI example, I think we  
16 talk a little bit about possible measures that  
17 can fit within domains, and which domains may  
18 be relevant for which particular phase in an  
19 episode-of-care.

20 But it is all subject, it's  
21 certainly all subject to interpretation and,  
22 certainly, there is some overlap.

1 DR. CAIRNS: And I just wanted to  
2 give one more comment, because the value and,  
3 frankly, the learnings we have had as a group  
4 interacting with NQF, who are clearly, you  
5 know, the experts and the leaders in this  
6 endeavor, is having this kind of formal  
7 approach.

8 So even though this framework is  
9 going to guide development and identify gaps  
10 and start to put this into a context of  
11 emergency care, understanding, you know, how  
12 the folks who do these performance measures  
13 think has been very helpful.

14 And so that's where the domains  
15 came from. We tried to put them in a  
16 structure where we could at least start to  
17 attack some issues -- and this is a draft,  
18 Jesse. So we look forward to where you think  
19 things might go, could go or intersect between  
20 different domains.

21 CO-CHAIR ROSZAK: Can we put all  
22 the domains back up there, just so we can get

1 a visual? Nick?

2 MR. NUDELL: I was waiting to see  
3 the slide. The medical care domain has three  
4 sub-domains, with the hospital components  
5 broken into two: emergency care and inpatient  
6 care. And I wonder if we might not benefit  
7 from having a similar approach to the out-of-  
8 hospital care, where there is a definite focus  
9 in some systems to respond to emergencies?

10 Then there is also a growing  
11 section that doesn't respond to emergencies,  
12 but is partially part of the prevention that  
13 Gary mentioned that has a different focus, but  
14 addresses the same system -- or we would want  
15 it to be a part of the system, rather than  
16 something not considered.

17 CO-CHAIR ROSZAK: Gary?

18 MR. WINGROVE: I don't know if  
19 this comment fits in this section or somewhere  
20 else, so I can bring it up another time, if  
21 that's more appropriate.

22 If we think about regionalization

1 as a population and systems of care serving  
2 that population, is there a chance we can get  
3 at the issue of people with time-sensitive  
4 life-threatening diseases arriving at an  
5 emergency department not in an ambulance?

6 CO-CHAIR ROSZAK: I mean, I  
7 certainly think all options are on the table.  
8 What do you think, Chuck?

9 DR. CAIRNS: Yes. I mean, I think  
10 that could end up in detection/identification,  
11 for example. It could certainly end up in  
12 terms of the Phase 2 of care, and in the  
13 disease state. And it could certainly be an  
14 integral part of communication with inpatient  
15 specialty services, for example.

16 So I do think that you could put  
17 in -- my interpretation -- the walk-ins to the  
18 emergency department.

19 CO-CHAIR ROSZAK: Kathy?

20 DR. RINNERT: Yes, as we are  
21 looking at this sort of linear progression,  
22 and I hear it coming from sort of different

1 directions on the table here, different  
2 comments about what about this part, what  
3 about that part? Where is the quality  
4 assurance in the feedback loop between these  
5 different steps that help the process to learn  
6 from itself and be self-improving?

7           Where is the quality assurance  
8 part? Would that be down with outcomes, where  
9 you are actually utilizing the final --  
10 whatever the final disposition is? The  
11 patient really didn't have an acute injury or  
12 illness, or they had a broken hip or whatever.  
13 And then you go back to say: well, how do we  
14 detect and identify?

15           Are we getting a bunch of broken  
16 hips from a certain nursing home, because  
17 there is a fall/trip potential? And who is  
18 going to go out and fix that thing? We need  
19 to have a way to identify quality assurance  
20 between steps, or maybe from the outcomes back  
21 to the detection and identification. And I  
22 don't know where that would fall or what we



1 would call it.

2 But the system has to learn from  
3 the things it is doing. And there has to be  
4 interaction between the different steps to  
5 help inform and make the learning happen.

6 CO-CHAIR ROSZAK: And I certainly  
7 think quality assurance should be built into  
8 probably all of these, but then also seeing  
9 this as one, you know, one picture, you are  
10 going to have that vision of what happened to  
11 make the 911 call all the way through what  
12 happened here. And I think that is going to  
13 make the quality assurance even more powerful.

14 Chuck or Jeff?

15 MR. WILLIAMS: I would just add,  
16 Kathy, I think that is one benefit of the  
17 episodes-of-care approach. I mean, I think  
18 depending on the specific measure that you are  
19 talking about, a measure of such concept could  
20 either fit in coordination of care or  
21 potentially outcome, just depending on what  
22 the measure itself was defined as.

1                   But the episodes-of-care approach,  
2                   as we sort of exemplified earlier, I think  
3                   Phase 3 is where some of that occurs, sort of  
4                   the ongoing care and/or continuity approaches  
5                   and/or looking at the processes that have come  
6                   before and where the opportunities are to  
7                   measure those.

8                   So I think depending on the  
9                   measure, it could be in one of multiple  
10                  domains, but the phase in which that would  
11                  occur is probably Phase 3.

12                  DR. CAIRNS: I turned it off,  
13                  sorry, Andy. I knew it would happen at least  
14                  once. Great, great comments, Kathy. So  
15                  imagine -- and we have got two separate  
16                  frameworks here. We have got these domains  
17                  set up. And then we also have this episode-  
18                  of-care model, where we have got different  
19                  phases within that episode-of-care.

20                  And I think in each and every  
21                  phase, I agree with Andy, there should be  
22                  quality assurance, and there should be loops

1 in that whole kind of quality management  
2 perspective.

3 Number two, you will be able to  
4 then define -- or at least identify --  
5 characteristics across phases that are  
6 important to both the units of service within  
7 that episode-of-care, as well as coordinating  
8 care for a specific disease state.

9 And, you know, we have got some  
10 small groups set up, if I understand  
11 correctly, Sally, and there are some specific  
12 questions that I think hit some of those key  
13 issues, because I think that those are what we  
14 were thinking were important.

15 CO-CHAIR ROSZAK: Go ahead, Jesse.

16 DR. PINES: You know, just looking  
17 at, you know, thinking about all the potential  
18 overlaps here, I know people have talked about  
19 prevention and, you know, healthcare versus  
20 medical care, and what we are talking about  
21 here. And I think that another potential way  
22 to organize it would be that, really, medical

1 care could be the kind of -- the kind of meta-  
2 dimension, and then underneath that you could  
3 have the different areas that people get the  
4 care, and then under that you could have  
5 potentially the different, you know, resource  
6 utilization, coordination of care.

7 Because really, you know, having  
8 medical care and coordination and resource  
9 utilization a separate dimension, I'm not sure  
10 it makes sense.

11 DR. CAIRNS: Well, we are open to  
12 all suggestions. Again, that was a draft just  
13 so we could get some of these issues out,  
14 understanding that the typical framework for  
15 these performance measures is to develop these  
16 domains, and from these kinds of perspectives.

17 So in that context, medical care  
18 is only one of many potential domains for  
19 quality or performance metrics. And that's  
20 why regionalization of care may be  
21 distinguished by its need beyond medical care.

22 So there has to be coordination of

1 care. There has to be this appropriate  
2 resource matching. There has to be  
3 identification across the system or, as we  
4 have had a pretty big discussion, an all-  
5 inclusive population within a defined  
6 geography.

7 And I think that is one of the  
8 challenges we face as we move to this  
9 dimension of regionalization of care, beyond  
10 specific components of medical care in the  
11 episode-of-care model.

12 CO-CHAIR ROSZAK: Yes, I mean,  
13 even issues like reciprocity, clearly, a great  
14 component of a regionalized system is  
15 reciprocity, so where would you, you know,  
16 plug that in? And that's not necessarily just  
17 inherent in medical care.

18 DR. PINES: Right. But if we  
19 think about, you know, where the sub-domains  
20 sit, I mean, we have resource utilization and  
21 coordination of care in the emergency  
22 department, in the out-of-hospital area, and

1 in the inpatient zone. And I think  
2 ultimately if we want to take performance  
3 measures and have them mapped back to  
4 dimensions, if it could be within individual,  
5 you know, kind of a unique bucket, you know,  
6 I think it is going to be a more sensible way  
7 to organize the domains.

8 DR. CAIRNS: Can I just make one  
9 comment to that? So, Jesse, thank you for the  
10 suggestion. Again, this is all valuable and  
11 if the group feels we can model it out any  
12 number of ways.

13 One thing I did want to  
14 distinguish, when we were thinking about  
15 these, we didn't think about a single unit of  
16 service in quality performance metrics within  
17 that unit of service. Especially measures  
18 that were exclusively within that unit of  
19 service, because we didn't think that that  
20 would be serving this concept of  
21 regionalization or system, because we wanted  
22 to get those components that would clearly

1 cross units of service, or that would clearly  
2 involve integrated systems of care.

3 And so going into a silo for  
4 emergency department care, while it may be  
5 extremely valuable to a broad population of  
6 patients and there may be good evidence for a  
7 specific performance measure, if that care and  
8 that performance is really isolated to the  
9 emergency department setting, then it may not  
10 be serving the purpose for regionalization,  
11 which is to try to understand that resource  
12 within this broader context.

13 And so that was one of the reasons  
14 that -- not push-back, just trying to absorb  
15 those perspectives.

16 DR. PINES: Well, just to trying  
17 to differentiate the different resources. I  
18 mean, we have the, you know, role of the  
19 emergency department as a diagnostic unit  
20 versus a treatment, you know, hospitals and  
21 emergency departments as treatment units. And  
22 if we -- and I think that there are probably

1 ways to regionalize both of those that are  
2 going to be somewhat overlapping, but not  
3 always overlapping.

4 I mean, you know, you can't -- it  
5 would be difficult to make the diagnosis of a  
6 subdural, if you don't have a CT scan. And I  
7 think when we start talking about a lot of  
8 these rural communities, you know, and  
9 regionalizing emergency services, it's not  
10 necessarily about putting a neurosurgeon  
11 there, but probably putting a CT scanner  
12 there.

13 So I think that kind of  
14 differentiating by zone is appropriate.

15 DR. CAIRNS: Thanks.

16 CO-CHAIR ROSZAK: John?

17 DR. FILDES: I am not sure it's  
18 the right way to go, but one of the things I  
19 have been trying to model here in front of me  
20 is using these in Column 1 and then creating  
21 three more columns to the right, one for  
22 population at risk, one for evaluation



1 management, and one for follow-up.

2 And mapping across, I was just  
3 looking at the 30 measures that you identified  
4 to see how they might fall in. And then the  
5 projects, you have 28 projects, I think, and  
6 30 measures that you identified.

7 DR. CAIRNS: Yes, John, you know,  
8 that was just to inform the concept here.

9 DR. FILDES: No, no, but --

10 DR. CAIRNS: Let's not be wedded  
11 to those.

12 DR. FILDES: No, I'm not, but I'm  
13 trying to make a point.

14 DR. CAIRNS: Yes, I understand.

15 DR. FILDES: Systematically, I  
16 think they drop in.

17 DR. CAIRNS: So, John -- can I  
18 comment on that, Andy? Great idea. In fact,  
19 one of the things that we were thinking of in  
20 the context of Helen's comments and,  
21 basically, an evolution of our thought from  
22 the discussion earlier, is that if you can

1        imagine, I just substitute your horizontal  
2        access for Phase 1, Phase 2, Phase 3 of the  
3        episode-of-care, and then I pile on top of it.

4                    And I suspect there are two things  
5        that are going to come out of that. Number  
6        one is that we are going to find that there is  
7        a baseline, Phase 1, Phase 2, platform that  
8        reaches across general elements of emergency  
9        medical care.

10                   And then I think there will be  
11        some condition-specific elements that cross it  
12        as well. And it will be interesting to see  
13        not just how it works out in terms of a grid,  
14        but how it might work out in terms of a map.

15                   DR. FILDES: And then within each  
16        of those cells, you would have to weight the  
17        value of the measure, because you could  
18        measures that would fit in each of those  
19        cells, but certain of them will have great  
20        value, while others may not.

21                   DR. CAIRNS: Frankly, I think we  
22        will find a lot of them don't exist and that

1 what we will do is we will give prioritization  
2 for identifying them, potentially, John. But  
3 that was my comment. Sorry, I was reacting  
4 though, because I think it's a good syntheses.

5 CO-CHAIR ROSZAK: Dr. Carr?

6 DR. CARR: Yes, it feels a little  
7 bit like there is something missing before  
8 detection and identification, like a system  
9 readiness kind of thing or some sort of  
10 incentive to be prepared to build it ahead of  
11 time.

12 And I don't know if that's the  
13 right structure to do it or if it's all rolled  
14 into Phase 1 each of these. I'm sort of on  
15 the fence there. But I love this idea of the  
16 X and the Y.

17 DR. CAIRNS: Great point, Brendan.  
18 And I think, you know, the Phase 1 discussion,  
19 I think, is going to be a critical one.  
20 Because, you know, frankly, our federal  
21 partners have been pushing us on this and  
22 appropriately so is how that infrastructure,

1       how we have these processes in place to take  
2       on these critical issues of preparedness, of  
3       diversion, of overcrowding, of surge and they  
4       are really important.

5               DR. RINNERT:  So perhaps the other  
6       along that same line, Brendan, may be  
7       capacity, capability, access is that first --  
8       because until you know sort of what is the lay  
9       of the land to detect and identify, it's going  
10      to be difficult, because you don't know what  
11      is the current state.

12              DR. CAIRNS:  Right.  That's great.  
13      I think we just got a sixth to match.

14              CO-CHAIR ROSZAK:  I like that a  
15      lot.  So, you know, I'm sure we all thought  
16      about this before we came here about what are  
17      some things that, you know, ideally if you are  
18      going to measure a regionalized system, what  
19      are things that you would look for?

20              So as you kind of go back through  
21      your mind and click off those items that you  
22      have thought about ahead of time, as we look

1 at these domains, is there anything else that  
2 we have missing? Are there buckets up here or  
3 are there buckets that are not up here that  
4 you would like to see that are important for  
5 measuring the system?

6 Nick, I know you have talked a lot  
7 about the public and the first responders and  
8 training of those people. Is there a category  
9 up here that you think you could plug into?  
10 Is there access issues that Ron has talked  
11 about at great length? You know, some of the  
12 stuff that Skip and Gary have talked about,  
13 the preparedness stuff that Brendan just  
14 mentioned, do we feel like these domains --  
15 and I think we should probably add that, a  
16 sixth one.

17 Is there anything else that is  
18 missing or that would, you know, be an  
19 addition to add greatly to the discussion of  
20 the framework? Art, you're back in time to  
21 comment?

22 CO-CHAIR KELLERMANN: Well, just

1 it's hard to keep wheeling my neck around.

2 The neurosurgeons have already had one whack  
3 at me, I don't want them to have another one.

4 Does resource utilization  
5 adequately encompass issues of lack of access  
6 due to overuse or unavailability of resources?  
7 So I'm thinking back again to capability  
8 versus capacity.

9 I mean, if we are on diversion, if  
10 all the ORs are full, if there is the one  
11 OB/GYN for the two counties is on vacation,  
12 because Lord knows she or he gets at least a  
13 week off a year, is that reflected in that  
14 domain or how do we address those issues?

15 I mean, are we going to -- you  
16 know, one would hope that if we do get to  
17 truly regionalized systems, that real time  
18 ongoing monitoring of capacity and low  
19 balancing is a really important part of that  
20 process.

21 And I just wanted to make sure  
22 that as we aspire to the future, that we are

1 both recognizing the importance of those  
2 issues and, in fact, measure those, so that we  
3 can see how systems perform.

4 MR. WILLIAMS: I will address that  
5 briefly. First of all, I will say that it's  
6 very easy, I think, for the group to take a  
7 look at the domains, especially since we have  
8 talked about the episodes of care approach as  
9 a longitudinal time-wise approach.

10 It's very easy to see the domains  
11 in a time-wise approach, too, but that's not  
12 necessarily the intent. I would sort of  
13 second Dr. Kellermann's comments that in the  
14 draft, at least as we have addressed it in the  
15 draft, some of the issues regarding access,  
16 regarding capacity, regarding, for example,  
17 our issues regarding crowding and diversion,  
18 those are discussed within the domain of  
19 resource utilization to some extent.

20 Now, clearly, that's not all  
21 utilization. Sometimes it is just a  
22 discussion of what structural measures could

1 potentially be there. But I think it's up to  
2 the group. I mean, I think, certainly, we  
3 could create a sixth domain that addresses  
4 specifically capacity, capability and access  
5 or we could fold it under resource  
6 utilization, although I agree that perhaps  
7 reordering them or possibly making them not as  
8 visually time-based would, perhaps, be more  
9 clear.

10 MR. KIRKWOOD: Much of the  
11 discussion today is centered around the  
12 episode of care model. The reason I would  
13 agree with an additional domain for sort of  
14 capacity and preparedness issues is because  
15 those things -- you can make a tie between  
16 them in the episode of care model, but it's a  
17 stretch to do so.

18 And it's also just one of the core  
19 issues when we talk about whether EMS fits in  
20 the realm of public health or medical care or  
21 public safety, that's the linchpin of that  
22 discussion there, because we don't pay for



1 preparedness and capacity in a system that is  
2 otherwise compensated for an episode of care.

3 CO-CHAIR KELLERMANN: Yes, just to  
4 point on that, it continues to drive me to  
5 distraction that we talk about surge capacity  
6 in this country, when we know on any given day  
7 or any given night how many hospitals are on  
8 diversion and how many EMS systems have no  
9 ambulance available and, yet, we talk about  
10 surge capacity.

11 And because we aren't tracking and  
12 reporting and aren't aware, you could go to  
13 the HHS Secretary's Op Center now and you  
14 would have no idea what the current load  
15 capacity of the major 20 metro areas in the  
16 country is.

17 I just think that's  
18 unconscionable. And so if we want to move the  
19 field, I think we do have to make sure that  
20 there are measures that if you call yourself  
21 a system, there are certain things you ought  
22 to be regularly mindful. One of them is your

1 load capacity and how much you are carrying  
2 and whether or not you've got folks off-line  
3 or not.

4 Dr. Fildes likes to pick on the  
5 FAA, but the FAA knows if an airport is open  
6 or it's closed and whether you are diverting  
7 a lot of air traffic. Yes, okay, got it.

8 MR. WILLIAMS: That would be a  
9 relatively easy job, because the truth of the  
10 matter is we probably don't have any surge  
11 capacity. We have the ability to move a  
12 problem around a little bit, but if you go to  
13 the metro area where I live, the average  
14 hospital is about 105 percent of capacity  
15 every day. And there is just enough  
16 ambulances and just enough paramedics to run  
17 the expected number of calls.

18 So, yes, we can move a problem  
19 from here to there and shift something in  
20 three hours or six hours or twelve hours, but  
21 right now, there is no surge capacity.

22 CO-CHAIR KELLERMANN: Well, with

1 all respect to our federal partners, I thought  
2 I read a report recently that we have lots of  
3 surge capacity and preparedness, because the  
4 hospital administrators said they had it.

5 CO-CHAIR ROSZAK: We will go over  
6 to Nick.

7 CO-CHAIR KELLERMANN: I'll be  
8 quiet.

9 DR. CAIRNS: Yes, I think that  
10 it's a good discussion point on whether or not  
11 to add a sixth domain. And I don't know  
12 whether it should be a set sixth domain or an  
13 experimental sixth domain, but, certainly, it  
14 has got to be incorporated in this capability,  
15 capacity and access. Because I think it kind  
16 of incorporates at least a lot of the  
17 discussion if people agree.

18 CO-CHAIR ROSZAK: Nick?

19 MR. NUDELL: Andy, you drew me  
20 back in. The area that could potentially be  
21 in resource utilization, but it's not a very  
22 good description for it, would be regulatory

1 issues. Scopes of practice, licensing,  
2 credentialing, those -- just kind of that  
3 domain of -- that includes training and  
4 education, the official act of allowing  
5 somebody to do something or to not do  
6 something, those kinds of things, I think, are  
7 also important to include in a system.

8 CO-CHAIR ROSZAK: Yes, I actually  
9 had that written down here and I was kind of  
10 struggling where I would plug that in, so I'm  
11 glad you reminded me of that and brought that  
12 up.

13 Any thoughts on that? And I want  
14 to make sure, Kristi, too, you had brought up  
15 e-health and, you know, all that, you know,  
16 utilization of technology and all that. I  
17 want to make sure that you are comfortable  
18 with the domains and there are places for you  
19 to plug that in and capture that, especially  
20 with all the great work you have been doing.

21 So I guess I'll just ask you, do  
22 you feel comfortable? Would this work for

1 you?

2 MS. HENDERSON: Yes, I think it  
3 crosses into several categories, coordination  
4 of care, several of them, so I'm comfortable  
5 with this. I do like adding a sixth category  
6 though.,

7 CO-CHAIR ROSZAK: Gary?

8 MR. WINGROVE: So I agree with  
9 Nick and just want to say it in a slightly  
10 different way. So we have population and a  
11 region. We have a system that has got a bunch  
12 of parts that are intertwined, but done  
13 separately. And so system governance then  
14 also becomes an issue of the feedback actually  
15 affecting the whole system and how that system  
16 is governed to make sure that all of those  
17 pieces are accountable.

18 CO-CHAIR ROSZAK: Arthur, you're  
19 right behind the picture there. Go ahead.

20 MR. COOPER: Yes, I agree with the  
21 access, capacity and capability sixth point.  
22 I'm wondering if number two should be

1 workforce and resource utilization in keeping  
2 with the points that have been made by Nick  
3 and others?

4 CO-CHAIR ROSZAK: Well, I think  
5 there is enough agreement that we should  
6 probably add that sixth bucket. And let's try  
7 to populate it tomorrow and just see what we  
8 come back with. And if we do see a lot of  
9 overlap, we can always condense it at the end  
10 of the day tomorrow.

11 But I think, at this point, in  
12 developing the framework we want to shoot for  
13 the moon and let's be all-inclusive and ask  
14 for all we can. And then if we have to pare  
15 it back or, you know, make changes to make it  
16 fit better into this model or this theme, we  
17 will do that.

18 But, you know, this is really a  
19 blank slate like we said in the beginning. So  
20 if you are setting up a system to look at  
21 regionalized medical care, what are the  
22 components? So let's not limit ourselves and

1 let's try to populate as many of these as we  
2 can.

3 Other comments or further  
4 discussion on the domains? I know we wanted  
5 to talk briefly about the different phases.  
6 We have got about a half hour until we break.  
7 Do we have the phase of care slide? Can we  
8 shove that back up on the screen for just a  
9 minute? I think somebody had that earlier in  
10 the day. Sorry about that.

11 And, Chuck, do you want to just  
12 talk a little bit more or maybe Sally might be  
13 more appropriate since you are more, you know,  
14 in tune to the NQF processes, but this was a  
15 process that was developed by the NQF, I  
16 believe, to look at other areas.

17 And we have kind of adapted it for  
18 our use here with some modifications as we  
19 have talked about today. So maybe do you want  
20 to just give a little bit of background and  
21 maybe describe how it has been used in other  
22 areas?

1 MS. TURBYVILLE: Sure. So as NQF  
2 has continued to work in both endorsing  
3 measures, but also guiding the development of  
4 measures, they realized that it would be a  
5 great idea to come up with a conceptual model.

6 And so through a lot of efforts  
7 and working with a consensus-based Steering  
8 Committee, such as yourself, it's also an  
9 endorsed-framework, this episode of care model  
10 was put forth.

11 And we have been applying it more  
12 and more as we move forward, but we realize,  
13 in particular, when we are talking about an  
14 area such as this where we are looking at  
15 systems, that it may not fit perfectly.

16 So when we challenged our team, I  
17 mean, UNC, to think about how this framework  
18 would work in the context of thinking about  
19 regionalized emergency medical care services,  
20 what we need, what we have now, where we need  
21 to go in the future, I think there was a lot  
22 of effort in thinking about that.



1                   And I think what we have learned  
2                   is that there is some advantages to this  
3                   model, but we also realized going in that you  
4                   are going to uncover some limitations. And so  
5                   there is a couple of options as we think about  
6                   this, whether it is adapting the model to make  
7                   it work.

8                   So perhaps -- I had a sidebar  
9                   conversation with Helen in thinking about what  
10                  you all were speaking about this morning that  
11                  rather than trying to produce an episode-  
12                  based model for each condition that may be  
13                  time-sensitive and life-threatening, is there  
14                  a generic model that thinks about the system  
15                  and then captures these cross-cutting measures  
16                  so that we are not trying to reproduce  
17                  measures that could actually look at the  
18                  system for every condition.

19                  And then as we think about  
20                  particular conditions that are lift-  
21                  threatening, that's where they enter in Phase  
22                  2 where they become an offshoot.

1           So an example, and I don't want to  
2           get into too much detail about you having the  
3           graphical example, there was an AMI episode  
4           done by one of the cardiac groups in applying  
5           this model and they had the AMI episode and  
6           then they had trajectories coming off of that  
7           for different types of severity that occurred  
8           with AMI, because the treatment and needs for  
9           those two populations was very distinct.

10           So taking that kind of approach  
11           and thinking about a generic model, this being  
12           the generic model, but really regionalized  
13           emergency medical care model and then maybe  
14           the trajectories are when needed for  
15           particular conditions.

16           And so to think about, as has  
17           already been started, this Phase 1 could  
18           perhaps be where we think about some of these  
19           preparedness issues. The population is the  
20           community that is going to be -- that you need  
21           to work through this emergency medical care  
22           system.

1                   So that's what we were thinking.  
2                   We know that there may be some limitations.  
3                   You may even identify some complimentary  
4                   conceptual model that needs to accompany this.  
5                   We are not trying to force any -- you know, a  
6                   square peg into a round hole or anything of  
7                   that nature, but it really is a starting  
8                   point.

9                   And I think we have learned a lot  
10                  already so far. So we offered it as a  
11                  conceptual model to this group and we would  
12                  like you to kick it around as much as you can,  
13                  take it where it can, and then also let us  
14                  know, you know, what and if there are  
15                  limitations to it.

16                  That said, I think we also want to  
17                  make sure we spend time talking about these  
18                  different phases and the trajectories that may  
19                  come off of this model to support the  
20                  measurement area.

21                  We do know that it does help  
22                  measure developers to think about where they

1 can start developing measures. It gives them  
2 a little bit more context, because it's -- so  
3 when you are thinking about a condition or, in  
4 this case, an emergency medical care episode,  
5 it's so broad and challenging that to provide  
6 more context within the different points is a  
7 helpful exercise to continue pushing us to  
8 better assessment and better quality.

9 CO-CHAIR ROSZAK: Thank you.

10 MS. TURBYVILLE: Okay. And so as  
11 far as the domains that have been put forth,  
12 I think what I have heard so far is right. I  
13 think we will find that the domains will come  
14 up at different points of this episode. The  
15 domains themselves don't have to only fit in  
16 population at risk for, you know, the first  
17 domain, etcetera.

18 So I don't think it is going to be  
19 -- we are going to have the same type of  
20 relationship. And, in fact, I can imagine  
21 that the domains in some kind of VIN diagram  
22 and then as we look at these episode of care

1 models, we might think about how to illustrate  
2 how the different domains interplay with the  
3 different phases.

4 I don't think we are going to have  
5 all of the first two domains just in Phase 1,  
6 the next domains in Phase 2, etcetera.

7 So if you think of resource  
8 utilization, that potentially would be a bar  
9 across the bottom that encompasses the entire  
10 episode related to emergency medical care  
11 services. The same with coordination of care.  
12 What will be helpful for -- in thinking in  
13 terms of assessing those is that there will be  
14 different types of services you would want to  
15 coordinate and assess the coordination or  
16 different types of services that you are going  
17 to see high or low utilization that you would  
18 want to measure, etcetera.

19 It doesn't, as said before, always  
20 get to appropriateness, but I do think there  
21 is room for measures of appropriateness within  
22 an episode of care.

1 Other components of the domains  
2 may focus more on certain phases and that's  
3 okay. I think we let the context and the  
4 content of the domains and the episode lead us  
5 in that direction.

6 CO-CHAIR ROSZAK: Very good. I  
7 think that's very helpful. So is there any  
8 other questions or concerns or inquiries about  
9 the domains and how they relate to the phases?  
10 Is that pretty clear?

11 What do we think about the episode  
12 of care model? Everybody seems to be -- is it  
13 something we could work with? Do you feel it  
14 will be a good fit? Is there things we need  
15 to define, Phase 1, Phase 3? See how it goes  
16 tomorrow? Take a break. Jesse?

17 DR. PINES: Overall, I think it  
18 looks good. One of the things you could  
19 consider is having another phase after Phase  
20 3, which -- and trying to differentiate  
21 hospital care versus what happens afterwards,  
22 because that seems to be all lumped in,

1 because, you know, lumping in ICU care with  
2 care coordination and integration back in the  
3 community seems pretty different.

4 CO-CHAIR KELLERMANN: It fits most  
5 of the time, but it doesn't fit load issues  
6 and it doesn't fit mass casualty events. And  
7 those are unique when we are talking about  
8 regionalized systems, as opposed to a typical  
9 NQF where we are analyzing quality of care for  
10 a particular clinical condition involving a  
11 particular patient.

12 So I think we just have to be  
13 constantly aware that this works within most  
14 context for an episode of care involving a  
15 patient with a life-threatening or time-  
16 critical condition. When you are talking  
17 managing emergency care in a community on  
18 Friday night or after a tornado, it is going  
19 to be very different.

20 DR. MAIER: I was just going to  
21 remind Art of his earlier comment that if you  
22 build in the capability as part of the

1 process, then you will be able to deal with  
2 the Friday night issues. So it does become  
3 covered within this paradigm.

4 DR. CAIRNS: And, Art, if I could  
5 just comment on that, because I think that  
6 we've got Phase 1 where you can put a lot of  
7 those kinds of issues in. I think that time-  
8 sensitive care and what works for a patient  
9 can work for 100,000 or 100 million patients,  
10 if we've got the appropriate conceptual  
11 framework, appropriate resource matching and  
12 then the appropriate drivers and philosophies.

13 Clearly, the specific measures for  
14 an episode of care for one patient aren't  
15 going to be the same as they are for 100,000  
16 or a million people, but that may be yet  
17 another reason why we need to add this domain  
18 and include that in there.

19 CO-CHAIR KELLERMANN: Yes. I  
20 think I am just attempting to be explicit in  
21 what NQF's mission is implicitly. We are  
22 measuring quality in order to improve it. And



1 in this case, we are discussing an approach to  
2 beginning to get our handle around quality for  
3 regionalized systems of care with a goal that  
4 we will help, in fact, fashion high quality  
5 regionalized systems of care.

6 So it's important to keep these  
7 concepts in mind.

8 DR. MARTINEZ: Yes, I think it's a  
9 bit of a conundrum trying to figure it out,  
10 because the episode of care model works well  
11 in many ways. And, you know, JCAHO and others  
12 use tracer methodology and that sort of stuff.

13 The thing that I -- taking Art's  
14 point is when you are measuring a system, one  
15 of the things that is not seen very well is  
16 what's the capacity? And then where are we in  
17 relationship to the capacity?

18 Interestingly enough, you know, in  
19 California years and years ago, they actually  
20 started making the hospital put on-line how  
21 many beds they had. It was fascinating  
22 because all of a sudden the diversion issues

1 disappeared, because we all knew. And you  
2 could see when people were getting their  
3 higher level, EMS could distribute better, so  
4 that was a system issue.

5 And the thing I'm interested in  
6 is, you know, as you start measuring, how many  
7 times you have capacity in a system, but not  
8 in a particular place? And that allows you to  
9 do system management performance, too.

10 DR. CAIRNS: I agree.

11 CO-CHAIR ROSZAK: Mike, Tom, John?  
12 Anybody from that end? Okay. Art?

13 MR. COOPER: Yes, somehow, you  
14 know, in speaking about the system as opposed  
15 to the condition, we need to really, I think,  
16 think to the phases more as input through  
17 output as opposed to, you know, the current  
18 definitions that are a particular condition or  
19 disease-related.

20 You know, capacity is certainly  
21 part of that, but it is, and a huge part of  
22 it, more than that as well. But I have to

1 think this through a little bit more, but I'm  
2 trying to think of how you could sort of take  
3 this model and following Sally's suggestions  
4 here kind of morph it a little bit, you know,  
5 so that it fits the system model a little bit  
6 better. I'll have to concentrate on that  
7 overnight.

8 But I think that, you know, when  
9 systems engineers look at systems, you know,  
10 they are always looking for, you know, the  
11 rate limiting step, you know, or steps. And  
12 I'm not sure that the episode of care  
13 explicitly captures that.

14 And again, I think Art's point,  
15 Rick's point, that capacity is a huge part of  
16 it is true, but there may be other factors as  
17 well.

18 CO-CHAIR ROSZAK: All right. We  
19 are almost to break time. Is there any other  
20 comments that we have? Any concerns or  
21 questions about the phases, about the domains?

22 Tomorrow, we will be getting into

1 small groups to work on the domains and you  
2 will be -- I believe we are going to have what  
3 five or six breakout groups? Is that right?

4 MS. TURBYVILLE: Three breakout  
5 groups.

6 CO-CHAIR ROSZAK: Oh, three  
7 breakout groups. I'm sorry.

8 MS. TURBYVILLE: Of six.

9 CO-CHAIR ROSZAK: Six people each.  
10 That's what it is. So be thinking, you know,  
11 throughout the day today and then tonight  
12 about some of the key indicators that you  
13 would like to see in each of these buckets or  
14 domains.

15 And you will have a chance in your  
16 small group to probably dive, take a deep dive  
17 into one or two of the domains, but then we  
18 will also convene as a group and, you know, be  
19 able to share. So don't think you will just  
20 be limited to those two domains or those three  
21 domains that your groups gets assigned.

22 We obviously want your input on

1 all of the domains, so be thinking about that  
2 tonight and the rest of the day.

3 So with that, I think, unless  
4 there is any burning issues, we are going to  
5 take a break now. And we got done a little  
6 bit ahead of time, which is good. So it's  
7 2:40. The next session is at 3:15.

8 Why don't we take about a 10, 15  
9 minute break and let's try to be back by 2:55.  
10 That will keep us ahead of schedule. So come  
11 back about 2:55 and we will adjourn back then.

12 (Whereupon, at 2:37 p.m. the  
13 above-entitled matter went off the record and  
14 resumed at 3:08 p.m.)

15 CO-CHAIR KELLERMANN: We are now  
16 going to shift to discussing Regional  
17 Emergency Medical Care Systems Guiding  
18 Principles. And again, Dr. Cairns, I believe  
19 we have some opening remarks and presentation.

20 And again, thank you all for your  
21 attention today and your diligence. If we do  
22 finish a little early, I don't think it will

1 be a tragedy, but only if we have exhausted  
2 this topic and exhausted our sponsors.

3 DR. CAIRNS: As a measure of  
4 efficiency, we will pick up where we were.  
5 And again, this is all in the draft report.  
6 We now move into this other key theme. We  
7 talked about definitions. We talked about  
8 domains. And now the framework guiding  
9 principles.

10 So the following principles are  
11 overarching themes that are intended to  
12 provide direction to the standard  
13 implementation of the regionalization of  
14 emergency medical care services framework and  
15 future development of measures and measure  
16 concepts within regionalized emergency medical  
17 care services.

18 Next slide. So here is the first  
19 proposed guiding principle. Regionalization  
20 of emergency care is a method of matching  
21 resources to needs in a timely fashion with a  
22 goal of improving patient-oriented care

1 outcomes. Regionalization does not equal  
2 centralization of care.

3 Next slide. Number two, the  
4 effective utilization of regionalization  
5 concepts cannot occur without addressing  
6 potential structural deficiencies in the  
7 emergency healthcare system, such as ED  
8 boarding, ED crowding and EMS diversion.

9 Three, identifying and evaluating  
10 measures of whole systems of emergency care is  
11 difficult due to the immature development of  
12 these systems. Measurement of regionalized  
13 emergency medical care services should strive  
14 to effectively measure system components as  
15 well as the system as a whole.

16 Four, measures used to judge the  
17 effectiveness of a system should include  
18 patient-oriented outcomes.

19 Five, system evaluation should  
20 promote shared accountability for the system  
21 successes and failures across units of service  
22 and in the system.

1                   Six, the development of  
2 regionalized emergency medical care services  
3 is an ongoing process with continually  
4 changing structure and process elements.  
5 Valid system level measures should detect and  
6 recognize improvement or lack thereof due to  
7 changes of a system's component parts and the  
8 communication and coordination between them.

9                   And that's it. So, Andy, I don't  
10 know if you wanted to go through each of these  
11 principles, if there is any value in doing so.

12                  MR. LOYACONO: Are these -- do you  
13 know what pages these are in the handouts, by  
14 chance?

15                  DR. RINNERT: 13.

16                  CO-CHAIR KELLERMANN: Yes, Chuck,  
17 I would suggest we go back and we will just go  
18 through each of these one at a time. And if  
19 you've got your handout, you should be able to  
20 pull them out.

21                  DR. CAIRNS: So in the document it  
22 is our page 13 of the framework report draft,



1 but No. 25 of the pages of the materials you  
2 have been given.

3 CO-CHAIR KELLERMANN: Any comments  
4 on suggested modifications to Principle No. 1?  
5 We can circle back to -- well, No. 1.

6 DR. FILDES: I was really pleased  
7 to see No. 1 and regionalization does not  
8 equal centralization, because particularly  
9 safety net hospitals and public hospitals end  
10 up bearing the brunt of this idea and just  
11 because, you know, they have docs in-house  
12 when the sun goes down, they become the  
13 regional experts on everything. So mitigating  
14 against that is very important.

15 DR. CARR: That being said, we  
16 probably should define it. I mean, I have  
17 seen this now happen a lot of times, you know,  
18 after the -- this is pretty prominent in the  
19 regionalization workshop from the IOM.

20 Is centralization defined  
21 somewhere?

22 DR. CAIRNS: No. In the

1 Kellermann dictum. I mean, I think that's one  
2 of these things this group could define as the  
3 differences -- and distinguish the differences  
4 between regionalization and centralization.

5 Okay. So the concept here --

6 DR. CARR: Hold on.

7 DR. CAIRNS: Okay.

8 DR. CARR: No, I mean, I think I  
9 understand it, but I guess I think that other  
10 people are going to be reading this and we  
11 might need to give a sentence or two.

12 DR. CAIRNS: Well, I think it is--

13 DR. CARR: I mean, it's a great  
14 point, Brendan. And you know, honestly, one  
15 of the issues that comes up just as background  
16 is that the idea of centralization, as John  
17 pointed out, is frequently confused. You  
18 could be the focal point for all care. You  
19 could be the focal point for emergency care.  
20 You could be the focal point for specialty  
21 care.

22 But the purpose of regionalization

1 might be to create a system. And where there  
2 is, for lack of a better word, a rational  
3 planned approach to the care of patients  
4 across a geography or a population with a goal  
5 of improving their outcomes as we have  
6 discussed earlier for time-sensitive life-  
7 threatening care.

8 And that would definitely  
9 distinguish centralization concept from the  
10 regionalization concept. It should be  
11 unselected, not planned, not defined for  
12 conditions with a specific patient-oriented  
13 outcome in mind. That may be one comparing  
14 contrast between the two.

15 CO-CHAIR KELLERMANN: Dr. Maier?

16 DR. MAIER: Just given the  
17 opportunity to flog that horse again, on one,  
18 which is one of these difficult paradigms of  
19 a vertically integrated horizontal system, I  
20 think one allows you to deal with what we are  
21 discussing earlier and that is that on the  
22 horizontal part, you have the standards of

1       what a regionalized care delivery system  
2       should be regardless of the disease, while  
3       allow the disease-specific vertical  
4       integration to utilize the same baseline  
5       standards, but then to become potentially  
6       unique to the institution and/or the disease  
7       to allow to be more robust.

8                   And I think approaching it that  
9       way with the baseline standards that all  
10      components regardless of what you focus on,  
11      whether it is cardiac, stroke, trauma are held  
12      to with a fiscally feasibility attendant in  
13      large degree to allow consistent recording and  
14      monitoring and then to allow for specifics  
15      based by disease and not all institutions  
16      being necessarily involved with each disease  
17      can pull that out and look at their own  
18      outcome standards on top of that.

19                   CO-CHAIR KELLERMANN: Does that  
20      work for people? Well, good. Having lost his  
21      tent, Dr. Maier is out for the rest of the  
22      afternoon. I'm sorry, I don't see any signs

1 over here.

2 Shall we move to No. 2?

3 DR. KUSSKE: What is actually  
4 happening now in southern California is that  
5 the trauma centers are de facto regionalized  
6 care centers. And so just about anything that  
7 comes up is sent to the trauma center to take  
8 care of.

9 And so that, in effect, is  
10 happening right now, at least in that part of  
11 the world. And it appears to be a situation  
12 where primarily unfunded patients are sent to  
13 these trauma centers to be taken care of.

14 And the guise that is used to  
15 refer patients is the -- is referred to a  
16 higher level of care as defined by EMTALA and  
17 that so far has been the standard operating  
18 procedure for lots of hospitals in southern  
19 California.

20 CO-CHAIR KELLERMANN: So you are  
21 saying in lieu of regionalization, you have a  
22 centralized system that's centralized based on

1 economics?

2 DR. KUSSKE: It seems that way.

3 CO-CHAIR KELLERMANN: And I think  
4 your colleague on the other side of the table  
5 had pointed out that these cases all tend to  
6 show up more often after hours?

7 DR. KUSSKE: Well, sure after 5:00  
8 in the evening and all day Saturday and  
9 Sunday.

10 CO-CHAIR KELLERMANN: Okay. Shall  
11 we go to No. 2? Leading off, Chuck, at No. 2,  
12 two thoughts. One would be possibly somewhere  
13 slipping in the word monitoring, because if  
14 you don't -- if we don't monitor these issues,  
15 we don't know that they are happening.

16 And the other which sort of speaks  
17 a bit to Dr. Kusske's comment a moment ago and  
18 to Dr. Fildes in the break is in addition to  
19 boarding, crowding and diversion, the fourth  
20 issue, I think we are seeing more and more, is  
21 on-call or gaps in on-call coverage, either  
22 because there aren't enough specialists or the

1 specialists aren't willing or able to take  
2 after hours calls. So you might want to add  
3 that as well.

4 Again, back to -- you know, a  
5 system may be capable, but not have the  
6 capacity for any of several different reasons.

7 MR. McCULLOUGH: Would the EMS  
8 faculty be a component? I'm not sure if there  
9 is geographic variation to that, but I know in  
10 rural parts of our state where -- it's a  
11 challenge, because of the lack of paramedics.  
12 I'm not sure about nursing shortages, if  
13 that's still an issue in some of the other  
14 areas as well.

15 CO-CHAIR KELLERMANN: Dr.  
16 Martinez?

17 DR. MARTINEZ: Yes, I agree with  
18 your comment about on-call. I would actually  
19 change the wording a bit, from my perspective,  
20 to access to appropriate consultation, because  
21 things like radiology, you know, and other  
22 things can be solved electronically.

1                   And just that also allows us down  
2                   the road to go straight from the EMS to  
3                   consultation.

4                   CO-CHAIR KELLERMANN: Good point.  
5                   Yes, sir.

6                   DR. KUSSKE: Well, there is one  
7                   more point to make and that is that if a  
8                   hospital has a specialist on-call and that  
9                   specialist won't respond for whatever reason,  
10                  that technically is a violation of EMTALA.  
11                  But CMS then looks at that as a deficiency in  
12                  that hospital and requires that the hospital,  
13                  such as a hospital that has the capability,  
14                  has to take the patient.

15                  So that there is a legal aspect to  
16                  this as well, which sets up that transfer  
17                  because of EMTALA.

18                  DR. CAIRNS: Yes.

19                  DR. KUSSKE: If you were a  
20                  physician, say a specialist on-call at  
21                  Harborview and you knew that some other  
22                  hospital in your area had specialists that



1       could take care of the problem, but they had  
2       refused to come in to see the patient, and the  
3       patient was referred to Harborview, you might  
4       be upset by that because they didn't show up.

5               The issue is that when that  
6       happens, CMS views that as a lack of  
7       capability of the hospital that the patient  
8       was initially referred to and so they think  
9       then that the hospital, such as Harborview,  
10      has to take the patient because they have the  
11      capability and the other hospital didn't --  
12      doesn't.

13             DR. MAIER:   So your proposal would  
14      be?

15             DR. KUSSKE:   Well, the --

16             DR. MAIER:   I mean, it happens all  
17      the time, you're right.  I mean, that's where  
18      half my patients come from that scenario.  I  
19      mean, I'm well used to it, but I mean what  
20      would you propose to get out of it.

21             DR. KUSSKE:   Well, I think it's an  
22      education issue.  I think that the hospitals

1 that are receiving these patients need to have  
2 more contact with CMS to define how they are  
3 being treated. If they don't, actually it's  
4 a violation of the law on their side if it's  
5 a lateral transfer, so they need to report  
6 this more often.

7 And I think this is just a matter  
8 of education more than anything else. I'm not  
9 sure that all the -- everyone -- all the  
10 administrators are aware of that aspect of the  
11 regulations.

12 CO-CHAIR KELLERMANN: Well, in a  
13 magical truly regionalized system, you might  
14 be able to identify that hospital be -- seems  
15 to only transfer patients after 5:00, weekends  
16 and major holidays or during the day when they  
17 are uninsured. And those patterns would be  
18 readily discernible over time if we were truly  
19 sharing data and managing it.

20 If it's a one off, it's a one off  
21 and no one every notices. So again, part of  
22 our idea, if we identify important data to

1 collect and understand to see about the  
2 quality of the system, it can actually make  
3 the system better and more accountable.

4 Dr. Fildes and then Dr. Pines.

5 DR. FILDES: Yes, just a follow on  
6 what you just described as a system where in  
7 advance you decided what the rules are, you  
8 monitor them. There is an enforcement arm.  
9 There is authority.

10 In regionalization, as you know,  
11 can occur without that thought. One of the  
12 best examples I'm trying to resolve right now  
13 is on hand surgery and replantation of hands.  
14 And if the only guy in the state is on his  
15 annual vacation with his family, then they  
16 don't have it and it has to go out-of-state or  
17 somewhere else.

18 It binds a region, but nobody  
19 planned it that way.

20 DR. PINES: Just the way that No.  
21 2 is written, so addressing potential  
22 structure of deficiencies in the emergency

1 healthcare system, such as boarding and  
2 crowding, in a lot of areas the, you know,  
3 crowding could be a demand issue that the  
4 structural deficiency is not an emergency care  
5 system, but it's in the wider healthcare  
6 system.

7           So I don't know if we want to go  
8 into that at all or have that discussion. I  
9 mean, if one of the reasons for, you know,  
10 boarding and crowding is that we are -- you  
11 know, that primary care doctor is just  
12 referring their patients in and not seeing  
13 them.

14           CO-CHAIR KELLERMANN: My personal  
15 sense is if we are paying attention to  
16 approximate complicating factors, that's  
17 realistically probably as far as we go, unless  
18 we want to manage the entire healthcare system  
19 of the country.

20           But I think my sense of this one,  
21 Chuck, is your intention is to say that we do  
22 live in an imperfect world and these are

1 important factors in terms of timely access,  
2 immediate access to care that need to be taken  
3 into consideration.

4 DR. CAIRNS: Indeed. It came out  
5 of a discussion, one, it's a recognition that  
6 the system has challenges. Number two, that  
7 it doesn't exist as a system really. And that  
8 this -- one of the things we need to do is to  
9 start making it a system.

10 And then number three, when you  
11 start looking at what the components of the  
12 system are, that there are challenges both at  
13 the unit of service level, but also that  
14 interfere with the interaction of the units of  
15 service to provide timely life-saving care for  
16 illness and injury.

17 CO-CHAIR KELLERMANN: Any other  
18 comments on Principle 2? Yes, here and then  
19 here.

20 DR. ZANE: One could say this is  
21 cause and effect and you could say that the  
22 inefficiencies or the deficiencies could be

1       caused by a lack of regionalization, so that  
2       if we were regionalized and efficient, we  
3       wouldn't have as much boarding or crowding or  
4       diversion.

5                So I don't know if it makes it  
6       redundant or appropriate as is.

7                DR. CAIRNS:  So I think it's an  
8       interesting hypothesis.  I think that we  
9       wouldn't -- we won't find that out until we do  
10      it, but I think that clearly we have  
11      unstructured patient resource matching going  
12      on right now.

13               And so this would clearly be an  
14      approach to a structure, matching of patients  
15      and resources.  And, again, I like that  
16      distinction we made between capability,  
17      capacity and access.  I think that that is one  
18      way to think of it.

19               CO-CHAIR KELLERMANN:  Gary?

20               MR. WINGROVE:  From the rural  
21      perspective, boarding, crowding and diversion  
22      aren't major issues.  They pretty much take

1 care of what comes in. But I was wondering if  
2 we could add a few words in between such as  
3 and boarding that might get at what Allen said  
4 and what the rural issues are and that's lack  
5 of paramedics mid-levels and physicians.

6 Many of the emergency rooms in our  
7 state aren't staffed by physicians any more.  
8 It is all mid-level. Some of them have  
9 telemedicine support and some don't. But  
10 those are the issues that we struggle with.  
11 The vast parts of the state don't have  
12 paramedics at all.

13 CO-CHAIR KELLERMANN: I wince at  
14 the term, but provider shortages or something  
15 of that sort would get at that in a generic  
16 way that encompasses -- yes, workforce  
17 shortages. Yes. Dr. Fildes, you were waving  
18 your --

19 DR. FILDES: Just to say on No. 2,  
20 you said it much more eloquently, but to  
21 revert back to the FAA analogy, there is no  
22 air traffic controller.

1 CO-CHAIR KELLERMANN: Yes.

2 DR. FILDES: There is nobody who  
3 is matching the systems capabilities with the  
4 patient flows and, you know, keeping an eye on  
5 things. So in real time, there really is  
6 nobody overseeing the system.

7 DR. CAIRNS: That's an interesting  
8 point. I think that you have taken it one  
9 step up and that is there was some discussion  
10 of guidance and there was some discussion of  
11 policy implications. And I think that it's an  
12 interesting point and it may be valuable for  
13 the group to highlight that.

14 MR. LOYACONO: Related to crowding  
15 and diversion is the holding of ambulances  
16 unable to off-load. It has an effect on the  
17 ability of the system to continue to respond  
18 on both in the urban and the rural areas. And  
19 if it is probably something that could be  
20 added, that would be great.

21 CO-CHAIR KELLERMANN: I do think  
22 as a collective group, we have come up with



1 the most trivial terms to describe the most  
2 serious behavior. I think many people call  
3 that parking. Boarding, it sounds sort of  
4 like no big deal, but, you know. Dr.  
5 Martinez?

6 DR. MARTINEZ: Well, I was going  
7 to support the wording here in a way, because  
8 he asked the question about boarding and  
9 should we include that? And the answer, I  
10 think, is yes, because that's the process  
11 measure, right? You can put your structure  
12 in, but if it doesn't affect these things,  
13 then you -- perhaps the way it is working or  
14 how you are doing it in terms of a process is  
15 not giving you the outcomes that you want.

16 So I like these ideas of having  
17 some linkage to the fact that we will create  
18 these programs and this will be the starting  
19 point. And as you build the program and you  
20 move into its performance, you should see  
21 these disappear.

22 CO-CHAIR KELLERMANN: Yes, Art?

1 MR. COOPER: Not meaning to open  
2 up a can of worms here, but -- what me, as  
3 John says. But I do think that as much as  
4 your point, Art, about not taking the entire  
5 healthcare system is true, we all recognize  
6 that there is a rate limiting step at the back  
7 door of the emergency department in terms of  
8 getting patients upstairs and that seriously  
9 limits capacity.

10 There are many reasons for that as  
11 you know far better than I. But I think that  
12 that's a point that somehow has to be, you  
13 know, touched on in this analysis. If that  
14 issue isn't fixed, you know, the throughput  
15 problems are going to continue. The boarding  
16 continues, the diversion continues, all of  
17 those issues continue.

18 And since what we are  
19 fundamentally about is ensuring access,  
20 capacity and capability for folks who really  
21 need emergency care, I think that does have to  
22 be addressed somehow.

1 CO-CHAIR KELLERMANN: I think we  
2 talked during the previous discussion about  
3 inpatient care as one of the domains. And  
4 three cheers to NQF for now starting to ask  
5 for measurements of things like time to a bed  
6 and throughput time in emergency departments.  
7 Although, one knows you can hide a lot of  
8 mischief above or beneath the median,  
9 nonetheless, it's a start.

10 MR. COOPER: I guess I'm  
11 suggesting that something should be added to  
12 this list to reflect that. I'm not sure what  
13 the wording might be. I'll leave that to  
14 smarter people than me. But I think something  
15 has to be mentioned.

16 CO-CHAIR KELLERMANN: Other  
17 comments? Shall we move to 3? No? We're  
18 staying on 2 for a moment.

19 DR. RINNERT: Just a quick  
20 comment.

21 CO-CHAIR KELLERMANN: Kathy, yes.

22 DR. RINNERT: We are using lots of

1 terms that are common to those of us here at  
2 the table and to those of us who do healthcare  
3 on a routine basis: boarding, crowding,  
4 diversion, the throughput is a good way of  
5 putting it, patient parking. Are we going to  
6 have a composite glossary or some appendix  
7 where these things are defined and it is not  
8 within the main body?

9 I mean, this is going to be a  
10 document to inform policy and decision makers  
11 who don't know these terms probably as well as  
12 we do. So I assume we are going to pull some  
13 of these buzz words out into a glossary or  
14 something for other folks to be able to  
15 interpret this correctly.

16 MS. TURBYVILLE: Yes, that's  
17 right. We want to make sure that it reaches  
18 as general an audience that is interested as  
19 possible. So we will work on beefing up the  
20 glossary with terms that are overly technical  
21 or emergense or whatever you want to call it.

22 CO-CHAIR KELLERMANN: So that

1 would seem to be a way, for example, to define  
2 centralization in this context means.

3 Boarding in this context usually means no  
4 inpatient bed available or at least -- blah,  
5 blah, blah, you know. So I think that's a  
6 great point well made.

7 Key Principle No. 3. Should I  
8 interpret silence as a general -- oh, Dr.  
9 Cooper, what do you have to say about No. 3?

10 MR. COOPER: I'm sorry. I don't  
11 like the word immature.

12 DR. CAIRNS: Fair enough. We  
13 agree.

14 MR. COOPER: It's -- there are  
15 systems that are immature. There is no  
16 question about it. But there are systems that  
17 are also very immature -- or very mature,  
18 excuse me, and we have an equally difficult  
19 time evaluating performance in some of them as  
20 well.

21 You know, there are disease  
22 entities for which, you know, quality measures

1 are well-defined, et cetera. But there are  
2 mature systems in which there are large  
3 numbers of patients for whom quality measures  
4 are not defined. And we have a hard time  
5 evaluating those systems as well. So I'm not  
6 sure what the word is, but I think it is not--  
7 immature captures only a part of it.

8 CO-CHAIR KELLERMANN: Maybe a  
9 period instead of a comma and dropping the  
10 last half of that sentence would suffice? It  
11 is difficult.

12 DR. CAIRNS: Yes. Thank you for  
13 those comments. You know, we are sitting here  
14 thinking we have so many challenges: data,  
15 integration, thinking of these as integrated  
16 units of service within episodes of care  
17 across regions, across geographies. It's just  
18 going to be difficult.

19 Although, I think there may be  
20 value for us to identify some things, Art,  
21 that we can highlight as either successes or  
22 ongoing challenges.

1 MR. COOPER: I mean, I think I  
2 might say -- I might not drop the second half.  
3 I might say due to the complexity or something  
4 along those lines, I think that's really more  
5 to the point. And it's really varying  
6 complexity as well. It's tremendous  
7 variation, as we all know, and complexity as  
8 well. But you know this better than I.

9 DR. CAIRNS: No, sir. I just  
10 would like to remind everyone, again, here we  
11 have got this electronic healthcare record and  
12 we have got this huge movement to integrate  
13 electronic healthcare information, yet the key  
14 component of our systems here, emergency  
15 medical services, is not necessarily mandated  
16 yet. So it's a challenge.

17 CO-CHAIR KELLERMANN: Yes?

18 MR. WINGROVE: It's hard to have a  
19 system without leadership. And it's hard to  
20 have leadership without good governance, and  
21 good governance really doesn't make any  
22 difference without accountability.

1 I'm wondering if there is a way to  
2 work in the words accountability and  
3 governance into that one?

4 DR. CAIRNS: The only concept I  
5 wanted to add to that would be -- oh, excuse  
6 me.

7 DR. RINNERT: Wouldn't those go  
8 into Item 6?

9 DR. CAIRNS: They could. They  
10 could also go into Item 2. You know, one of  
11 the challenges we have both in terms of  
12 governance and accountability is -- and it  
13 could go into here -- is leadership. And  
14 again, I think there are policy implications  
15 for that in addition to governance and  
16 structure.

17 CO-CHAIR KELLERMANN: Yes, I would  
18 encourage the group to remember when we get to  
19 the point, and we are not there in this  
20 meeting, but to actually develop measures.  
21 It's also issues like validity, interlayer  
22 reliability, et cetera. Leadership, you can



1 see it when you see it, but it is awfully hard  
2 to quantify or define or measure in a system.

3 Other comments about No. 3 or  
4 shall we move to No. 4? Number 4, if Dr.  
5 Martinez was here, he would say -- oh, you are  
6 here, Dr. Martinez. In the spirit of Dr.  
7 Martinez, might we consider, should we or is  
8 it necessary to say, in addition to patient-  
9 oriented outcomes, patient-centered processes  
10 of care or is that a little too pompish and  
11 over the top?

12 We talk about structure. We talk  
13 about outcomes. Do we need to talk about  
14 measures that actually reflect the patient's  
15 experience? Rhetorical question.

16 DR. CAIRNS: I can give you a  
17 perspective and that is that I think the  
18 challenge here, if we get into too many  
19 process-oriented components, that we need to  
20 maintain credibility, validity and impact and  
21 probably value to the broader organizations,  
22 including CMS.

1 CO-CHAIR KELLERMANN: Some might  
2 say NQF has done a very good job of developing  
3 process measures. It's the outcome measures  
4 that are more of a challenge, to those are  
5 admirers of the six hour pneumonia rule. Dr.  
6 Martinez, you had something you wanted to say?

7 DR. MARTINEZ: I was going to say,  
8 you know, actually the best presentation I  
9 ever went to -- I used to be on the board of  
10 the Public Health Foundation -- but they gave  
11 a presentation on patient satisfaction or  
12 customer satisfaction in public health, which  
13 I thought was going to be a waste of my time.

14 And it turned out to be really  
15 fascinating, because they talked about, you  
16 know, the way it works is when you look at  
17 what you -- you are measuring all these  
18 surveys, which is why I hated them, because  
19 you are measuring after the fact and you are  
20 getting what they experienced.

21 And the question is what were you  
22 trying to give them? And then to do that, you

1 actually have to talk to the patients, right,  
2 and see what they need and what they want.  
3 That's a concept that's very foreign to many  
4 of us.

5           So, you know, what I like about  
6 the movement toward it is that a lot of our  
7 systems are set up based upon what is  
8 convenient for either the hospital or the  
9 physicians or the nurses. We just talked  
10 about boarding and everything else.

11           So I really think that if you  
12 drive it, like STEMI or our colleagues in  
13 surgery did a long time ago, let's just own  
14 the patient and do surgery, then you end up  
15 with a better system that actually meets the  
16 need of what it is supposed to be designed to  
17 do.

18           So I'm not so much against saying  
19 patient-ordered processes on there as a way to  
20 help define that, because I don't think  
21 patient-ordered outcomes is -- it's pretty  
22 vague to me also, I guess, you know?

1                   So I leave it for us to discuss,  
2                   but I think in the end, if you look at even  
3                   the measures of value, they are going to put  
4                   30 percent of some of the monies coming down  
5                   the pike are based upon patient satisfaction  
6                   and that, to me, is kind of overkill.

7                   But the message that is coming  
8                   down is that we have to design these things  
9                   based upon what the patient needs and how it  
10                  works for them.

11                  DR. RINNERT: And maybe this is a  
12                  segue off of that, but I think our patients  
13                  certainly expect their experience to be  
14                  efficient. And it is amazing even within my  
15                  own system, they go from one doctor to the  
16                  next to the next to the next trying to get  
17                  something accomplished.

18                  And it may in the end be  
19                  effective. It may even be efficacious, but is  
20                  it efficient? So I don't know if efficiency  
21                  needs to be worked in there somehow. Because  
22                  the shortest point from A to B is probably the

1 best for the patient, system utilization, et  
2 cetera.

3 CO-CHAIR KELLERMANN: Mr.  
4 Kirkwood? We will just work up this side of  
5 the table. This is the verbal half of the  
6 table anyway.

7 MR. KIRKWOOD: It may be implicit  
8 in, or just understood in, within the confines  
9 of this group, but I haven't heard the words  
10 evidence-based when we talk about performance  
11 measures yet.

12 DR. RINNERT: We don't have the  
13 measures.

14 MR. COOPER: That was one of the  
15 points I was going to make, although coming at  
16 it from a different angle. The movement, as  
17 Rick has pointed out, to look at the world  
18 from the patient's perspective is a very  
19 important and powerful, you know, tool in our  
20 armamentarium to improve quality of care.

21 However, the fact is it's a heck  
22 of a lot easier to send a survey to a bunch of

1 folks after their hospitalization, than it is  
2 to try to figure out, you know, robust outcome  
3 measures that are disease-specific.

4 And, you know, in my own system,  
5 we face this on a regular basis. You know,  
6 department heads are routinely judged on their  
7 HCAP scores, but not on the actual outcomes of  
8 the patients in their departments, because  
9 there aren't any robust outcome measures.

10 And I just worry that if we, if  
11 you will, overemphasize the, you know,  
12 patient-centered component that that will be  
13 missing the outcomes component just because  
14 measuring patient satisfaction is more than a  
15 little bit easier.

16 DR. MARTINEZ: Can I just make a  
17 quick comment? I know you've got a whole  
18 table full, but let me just clarify my point.  
19 I don't really care about patient  
20 satisfaction. Let me stay that again, okay?  
21 The reason why is because exactly what you are  
22 saying, but for the cardiologist, I used to be

1 the most highly paid secretary in the room  
2 making multiple calls to take care of my STEMI  
3 patients.

4 For somebody to say, you know,  
5 what's good for the patient? 90 minutes to  
6 the cath lab. Let's do it. That drove all of  
7 these systems, because it was patient-  
8 oriented.

9 You see the same thing coming down  
10 with sepsis, things like that. So I agree  
11 with what you are saying. The outcome -- it  
12 has to be evidence-based, right? Okay.

13 CO-CHAIR KELLERMANN: Brendan?

14 DR. CARR: I don't know if this is  
15 the right place for it, but when I think about  
16 patient's perspective, I think about how I  
17 would go about looking for my healthcare, and  
18 I go about that by fact-finding. And I just  
19 don't know how well we arm patients to fact-  
20 find.

21 So I'm wondering about  
22 transparency, about emergency care resource

1 availability. We've talked now about  
2 strategically aligning EMS practices with  
3 emergency care or hospital-based emergency  
4 care practices, but if I'm -- if I decide to  
5 drive in a rural area, my uncle -- rural is a  
6 bad example; there are probably fewer  
7 facilities.

8 But even a densely populated area  
9 and I decide to drive my family member to the  
10 hospital with their crushing chest pain, I  
11 don't have a 12 lead, but I still might want  
12 to know where the cath labs are. The idea of  
13 consumer-driven healthcare is an important  
14 thing. And I don't see -- we have talked  
15 about before, I have talked to the surgeons a  
16 great deal about their decision to be very  
17 transparent in what is provided and what the  
18 resources are for a Level 1 versus Level 2  
19 versus a non-trauma center and we have never  
20 decided to do that in emergency care more  
21 broadly.

22 And I wonder if it is at least a



1 dialogue that we should be having?

2 CO-CHAIR KELLERMANN: Ron?

3 DR. MAIER: I was just going to  
4 extend on the earlier comments from Richard  
5 and maybe we could just add at the end of this  
6 "and accountability" to also get towards the  
7 oversight requirement also? But to just make  
8 it patient-oriented outcomes and  
9 accountability to the patient is maybe a way  
10 to start integrating that into this process.

11 CO-CHAIR KELLERMANN: Works for  
12 me. It also has the virtue of brevity, but it  
13 says a lot. Other comments about 4? Jesse?

14 DR. PINES: I mean, I disagree a  
15 little bit about, you know, not caring about  
16 patient satisfaction. I mean, when it comes  
17 to regionalization and moving people for long  
18 distances where, you know, their family may  
19 not have the resources to come visit them in  
20 the hospital, I mean, I think that we have got  
21 to have something about, at least, patient  
22 preferences and balancing patient outcomes and

1 patient preferences in this in order to be  
2 complete.

3 CO-CHAIR KELLERMANN: Other  
4 comments? Number 5, here is that  
5 accountability word again. Any comments,  
6 modifications, observations about Principle  
7 No. 5?

8 DR. WRIGHT: Just to the point  
9 made earlier about our need for definition and  
10 glossary. When I see units of service there,  
11 we'll need to make sure that we have an  
12 understanding not just amongst ourselves, but  
13 for the consumers who will see that term.

14 CO-CHAIR KELLERMANN: Other  
15 comments? Nick?

16 MR. NUDELL: When I think of  
17 accountability I'm thinking of transparency  
18 and some way to promote the transparency, so  
19 I understand the point being described, but  
20 there is not really a mechanism of how it  
21 would be accountable or some kind of method or  
22 who it would -- so I guess is it a point of

1 you send a letter to each of your patients and  
2 you say here is how you rank compared to all  
3 my other patients or is it a website? No,  
4 seriously, you know.

5 Is it a website where you direct  
6 them to and there are some graphs and charts  
7 or is there a report done annually? Do we  
8 send them to Medicare's website or things like  
9 that?

10 DR. RINNERT: That's sort of to  
11 Brendan's point. Give to the consumer so they  
12 can choose ahead of time who they are going to  
13 go to or if I'm going to refer a family member  
14 in Des Moines, Iowa to somewhere that I don't  
15 know anyone up there?

16 CO-CHAIR KELLERMANN: One could  
17 imagine system evaluation should promote  
18 transparency and shared accountability. I  
19 want to ask Chuck. When you talk about before  
20 we defined and "units of service," what was  
21 the purpose of adding "and units of service"  
22 to the segment for the system successes and

1 failures?

2 DR. CAIRNS: So that concept came  
3 out of actually a Macy Foundation effort in  
4 looking at future research directions in  
5 emergency care. And in one of those  
6 prescribed papers on new methods to assess the  
7 outcomes of emergency care, we borrowed this  
8 concept that an emergency department is a unit  
9 of service in an episode of care.

10 So if you think of the unit of  
11 service being an emergency department in that  
12 episode, another unit of service might be the  
13 EMS system, another unit of service might be  
14 even community engagement, another part of  
15 that service might be specialty care and  
16 consult and another service might be intensive  
17 care unit or surgical care.

18 So I think the key point here is  
19 to have shared accountability across these  
20 units so they are not done in isolation. So  
21 the emergency department is not in isolation  
22 and the EMS system is not in isolation of the

1 rest of the components.

2 So that was the rationale part for  
3 putting that in there.

4 CO-CHAIR KELLERMANN: Is that  
5 clear to everybody?

6 DR. MAIER: Just -- do you have an  
7 example of where that has ever happened? I  
8 mean, not meaning that -- that doesn't mean we  
9 shouldn't do it. I'm just wondering do we  
10 have an example of like a hospital sharing a  
11 bad outcome with the local fire chief?

12 DR. CAIRNS: So, Ron, it is  
13 interesting we actually do. And so one  
14 example that comes to mind immediately is that  
15 one of the American Heart Association criteria  
16 for STEMI recognition, and they have an award  
17 program where they give a gold, silver, bronze  
18 recognition, has moved from door-to-balloon  
19 time to interaction-with-first-provider-to-  
20 balloon time.

21 And so you know get shared credit  
22 or shared failure with your EMS system. And

1 I think that is one step, at least, in terms  
2 of publicly recognized. It is a national  
3 recognition program. For those of you who  
4 have to interact with this, you will recognize  
5 how challenging that can be, how important a  
6 step that was in terms of integrating the two  
7 and I thought it was a nice first step, in  
8 terms of thinking of episodes of care with  
9 real world examples.

10 DR. MAIER: I was going to say it  
11 just might be nice to actually throw that in  
12 there, because there is not a whole lot that  
13 I know of.

14 DR. CAIRNS: Yes, we agree.

15 CO-CHAIR KELLERMANN: Other  
16 comments on this one?

17 MR. LOYACONO: I would just offer  
18 an example. We participate in that program  
19 and it is successful and our people are  
20 excited about it. We also have a program with  
21 our trauma team, for lack of a better word, we  
22 do an M&M pre-hospital with the trauma group

1 looking at outcomes, both good and bad. It  
2 was pretty unique.

3 DR. WRIGHT: And the idea of  
4 shared accountability should not just be  
5 limited to outcomes. As I'm listening to you,  
6 Chuck, I'm thinking here about this sixth  
7 dimension that we have added now at the top,  
8 an example that was mentioned earlier about  
9 full transparency of capability, bed  
10 capability, that an entire system is fully  
11 aware of and can see.

12 We have such a system in Maryland  
13 where every hospital can see exactly what bed  
14 status is. Every hospital can see what its  
15 emergency department status is. And it has  
16 impacted the whole diversion rate thing, but  
17 in terms of that dimension at the very top, I  
18 forgot what -- what we called the readiness  
19 dimension there.

20 DR. CAIRNS: I like your words,  
21 Joe.

22 DR. WRIGHT: The concept that the

1 -- certainly, from the out-of-hospital, pre-  
2 hospital component into the emergency  
3 department component transparency there is  
4 very important and I think about that when we  
5 are talking about this particular principle.

6 CO-CHAIR KELLERMANN: I'm reminded  
7 of Kristi's next door neighbor in Alabama, Joe  
8 Acker has a system like that that is very much  
9 an honor-based system where hospitals  
10 volunteer their report to a single office with  
11 a desktop PC and a handful of paramedics and  
12 a telephone and it's an honor system, but the  
13 CEOs actually meet bi-quarterly to go over  
14 their data, how often they were on diversion,  
15 what were the reasons, et cetera.

16 And his comment to me at the IOM  
17 Regionalization Roundtable were that they keep  
18 each other honest. If they sent their number  
19 two or number three or number four, it would  
20 fall apart. But since the CEOs come and  
21 confront one another, everybody plays.

22 Again, it's a one-off system that



1 is unusual drawn by the commitment of people,  
2 but it does reflect shared accountability.

3 DR. CAIRNS: And the impact of  
4 leadership.

5 CO-CHAIR KELLERMANN: Shall we  
6 move to No. 6? We're on a roll. Chuck, I'll  
7 chime in here for a moment and simply say I  
8 struggle a little with the term continually  
9 changing structure and process elements. I  
10 was thinking, you know, it is an ongoing  
11 process and certain structure process elements  
12 may change for something, just so it doesn't  
13 sound quite as amorphous.

14 I would wonder again if I were a  
15 new person coming into this process and saying  
16 what's the point? If you are going to keep  
17 reinventing your terms every few months, you  
18 can't really measure the tracking. I just  
19 reflect the fluidity of this, but I think we  
20 also have to have a little different sense.

21 DR. CAIRNS: Art, well, a point  
22 well-taken.

1 CO-CHAIR KELLERMANN: Other  
2 thoughts? Ron, you are smiling like you have  
3 something you want to say.

4 DR. MAIER: I'm very pleased.

5 DR. CAIRNS: Ron knew I was trying  
6 to be as short as I could.

7 CO-CHAIR KELLERMANN: Other  
8 comments? Are we beating this group to death?  
9 Jesse?

10 DR. PINES: Just the issue of --  
11 it says valid system level measures. I mean,  
12 I think that there may be measures at  
13 different levels. So I don't know if we want  
14 to box into system level measures there? Just  
15 a thought.

16 DR. CAIRNS: Jesse, good point.  
17 Just for clarification, the reason we put in  
18 system level measures is because we are  
19 looking at both the systems component in that  
20 second part of the sentence, and then  
21 coordination between them. So again, the idea  
22 is to get away from isolated units of service

1 specific measurement.

2 But, obviously, there are going to  
3 be components within that unit of service that  
4 may contribute to overall system performance  
5 but that's the point is you are looking at  
6 system performance not unit of service  
7 isolated performance.

8 CO-CHAIR KELLERMANN: Other  
9 comments or observations about Principle 6?  
10 Before we leave this topic, are there other  
11 principles or issues not embodied in these six  
12 that any of you think are fundamental to our  
13 goal of identifying important principles or  
14 concepts for quality measurement in  
15 regionalized systems of emergency care?

16 Is there something that is not  
17 here that we are overlooking that we have not  
18 addressed as we have gone through the  
19 discussion of these six principles?

20 Dr. Martinez and then Dr. Pines.

21 DR. MARTINEZ: Yes, just a quick  
22 comment. I think this is all great. And I

1 think we are learning a lot. But, you know,  
2 I have heard reference to some of the  
3 characteristics or attributes and quality from  
4 IOM and I'm not sure they are reflected in  
5 here, whether it is timeliness or evidence-  
6 based or patient-centered.

7 So we may want to consider at  
8 least a point that talks about that, or  
9 recognizing those attributes as being part of  
10 what the system would provide.

11 DR. PINES: Yes, one of the things  
12 that I don't see here is any discussion about  
13 how the different regionalization efforts may  
14 overlap with one another and how they may be  
15 complimentary or not complimentary, depending  
16 upon the disease area.

17 And I'm not sure if we want to  
18 create a new principle around that, but I'm  
19 sure that will be one of the pragmatic issues  
20 that come up.

21 CO-CHAIR KELLERMANN: You know,  
22 everybody may read into it what they will. I

1 sort of thought that in the statement  
2 regionalization does not equal centralization,  
3 that's another dimension of -- centralization  
4 requires everything to one place and,  
5 obviously, different places could be effective  
6 for different things, but I hear what you are  
7 saying.

8 Ron, go ahead, you've grabbed your  
9 button and then we will go down here.

10 DR. MAIER: I was just going to  
11 reinforce that concept, because I agree with  
12 what you said. I would assume that becomes  
13 part of it, but it's such a major problem in  
14 this country right now that the regional  
15 territories are like walls that no one goes  
16 over to integrate the care across those  
17 boundaries.

18 And maybe we need to be explicit  
19 in saying that we expect this system be a  
20 national system in the end product and the  
21 regions are going to integrate fully to give  
22 optimal care, and not have the boundaries that

1 no one can cross.

2 CO-CHAIR KELLERMANN: John?

3 DR. FILDES: This discussion took  
4 place with -- talking about the CDC field  
5 triage criteria and we had a big panel a  
6 couple weeks back and a few of you were there.  
7 But this concept of a defined trauma system,  
8 let me do strike, define emergency care  
9 system, was that there are a lot of places in  
10 the country where three or four states come  
11 together, like the quad cities, and a defined  
12 system has to dissolve geopolitical barriers.

13 So you know, that was a bright  
14 moment in the room when the decision was made  
15 to actually put that in print, to say  
16 something like that, that a defined system of  
17 care dissolves these geopolitical boundaries.  
18 And so perhaps that same thought could be  
19 incorporated here.

20 A separate comment on this, you  
21 were kind of asking for last call on comments,  
22 is I don't think there is a strong enough

1 statement in here about a system requiring --  
2 enabling legislation in a lead governmental  
3 agency and some oversight with command and  
4 control and authority to monitor and to make  
5 accountable the parties who participate in the  
6 system.

7 And I don't think that you have to  
8 go overboard with it, but these are really,  
9 really good thoughts and the next question is,  
10 well, who is going to do it?

11 CO-CHAIR KELLERMANN: Well, I  
12 don't want to parse this issue too finely and  
13 I do want to look back to the NQF staff folks  
14 as to what sort of in-scope for NQF and what's  
15 out-of-scope.

16 Clearly, I think that -- it is my  
17 sense that a number of the federal partners in  
18 the room and a number of us at this table  
19 believe that those issues are important,  
20 whether this process is the vehicle to advance  
21 that or not, I don't know and I would have to  
22 ask the NQF folks.

1 MS. TURBYVILLE: That's a good  
2 question and I don't have an answer today on  
3 how far we want to push that on that  
4 framework, but we have got it down and we will  
5 certainly discuss with Helen. I have seen  
6 some frameworks pushed very hard beneath the  
7 leadership, so my sense is that there is  
8 definitely a possibility to emphasize that  
9 need.

10 DR. CARR: One other word to  
11 consider, the word population or population  
12 health isn't in there anywhere and I just  
13 wonder if we could add to No. 3 something  
14 about future measurement regionalized  
15 emergency medical care services should try to  
16 effectively measure system components and  
17 population level outcomes or something of that  
18 nature, as well as the system as a whole.

19 I just think that once we -- when  
20 we really encourage people to sort of zoom out  
21 from their hospital's outcomes, even though we  
22 keep saying the word system, I think we might



1 want to be a little bit more explicit and say  
2 that we are talking about their catch area,  
3 their population, you know, the community, how  
4 it would be defined.

5 CO-CHAIR KELLERMANN: Brendan, I  
6 think it is a good point. I actually think it  
7 might even fit better in No. 1 right up front  
8 if you just said with a timely -- with the  
9 goal of improving patient-oriented care  
10 outcomes and population health, because you  
11 are really talking about outcomes across the  
12 population. And I think you would get at it.

13 Dr. Cairns, do you consider that a  
14 friendly amendment?

15 DR. CAIRNS: I do.

16 CO-CHAIR KELLERMANN: We notice  
17 you are getting briefer and briefer. And we  
18 appreciate it.

19 DR. CAIRNS: Thanks.

20 CO-CHAIR KELLERMANN: Next, we  
21 we'll get the monosyllabic grunts and then we  
22 are there. Any other comments or observations

1 on this general topic?

2 Hearing none, I believe that our  
3 last items of business, but an important one,  
4 is NQF Member and public comment. At this  
5 point, the hardcore observers in the room have  
6 just as much right to search the microphone as  
7 those of us who have been wearing them out at  
8 the table.

9 And anyone at the table who has an  
10 issue that they didn't feel was adequately  
11 addressed or commented upon earlier today that  
12 they would like to bring up, this is where  
13 oftentimes committees say any new business.

14 So if there are issues that we  
15 have not addressed over the course of this  
16 conversation, and I particularly want to  
17 invite individuals who are either in the  
18 audience or listening in on the telephone, Dr.  
19 Boyd, this would be a good time to speak up.  
20 I want you to tell David I specifically asked  
21 him in case he had been on the phone.

22 Going once, going twice. Everyone

1 feel, at this point, that they have been able  
2 to express -- again, at the risk of beating a  
3 dead horse, this is a very high-powered group.  
4 And I think we have had a really highly  
5 productive discussion today.

6 Chuck is still smiling sort of.  
7 And I think staff have gotten a lot of notes,  
8 both on their laptops and in recording. But  
9 I do want to make sure that given the rigors  
10 that everyone went to to come to this meeting,  
11 that your perspectives and those of your  
12 respective disciplines and background have  
13 been adequately represented in the discussion  
14 up to this point.

15 Obviously, we have got some  
16 opportunities to reflect tonight and again to  
17 re-engage tomorrow, but I want to make sure we  
18 have covered the grounds today.

19 I think there were perhaps some  
20 questions you wanted to ask people to mull  
21 over?

22 MS. TURBYVILLE: Yes.

1 CO-CHAIR KELLERMANN: Back to you,  
2 Sally.

3 MS. TURBYVILLE: Okay. That  
4 sounded like a cricket. A couple of things as  
5 we close out for today. One, we did hand out  
6 the packets to each of you for the work groups  
7 assignments tomorrow. They are meant to both  
8 reflect what we know about your expertise and  
9 some of your recent efforts, as well as still  
10 trying to construct representative work groups  
11 from the Steering Committee itself.

12 We attach to our best that we  
13 could -- the relevant component of the  
14 framework for the domain that we ask you to  
15 look at, so hopefully that will be helpful and  
16 I think it's good for you to have ahead of  
17 time an idea of what work group you will be  
18 participating in tomorrow. We're really  
19 looking forward to the outcome of that.

20 And then concurrent with this, we  
21 are going to have Chuck and Jeff start  
22 thinking about the new domain, and we don't

1 have a lot of time to do that, but have a lot  
2 of knowledge to pull from. And so we will  
3 still take advantage of that time tomorrow to  
4 push that sixth domain forward.

5 Some of the things that you may  
6 want to think about as we push, especially,  
7 the domains and the sub-domains that we have  
8 talked about this evening -- and feel free to  
9 jot these down as you watch the news later on  
10 tonight or as you wait for our dinner later  
11 tonight -- is to think about what has worked  
12 as far as measurement in the system or the  
13 regionalization so far and what should  
14 continue to be supported, so, you know,  
15 thinking about examples of successes, what do  
16 we have now in terms of measures and platforms  
17 or systems?

18 And I'm not talking about the  
19 systems that you have identified here, but the  
20 systems that allow for measurement that should  
21 be encouraged to assess the system, so perhaps  
22 the measures are too discrete right now, but

1 potentially could work in the context of  
2 regionalization.

3           So in thinking of your experience,  
4 are there measures that you think we should --  
5 and we don't have to name the measures, but  
6 types of measures, process measures, for  
7 example, that may be easy to adjust into  
8 regionalization or not, and areas that we know  
9 require measures that don't have any at all  
10 right now.

11           And for those that don't have any  
12 at all right now, thinking about why not. Is  
13 it the lack of data or the lack of integrated  
14 data? Sometimes we know we have a lot of  
15 data, but it's too fragmented. Is it a  
16 certain emerging clinical area and so it just  
17 hasn't had the opportunity for measures to  
18 come about, the clinical evidence, what have  
19 you, and others.

20           So to not just think about areas  
21 where nothing is there, but really start to  
22 push this Committee to think about why not.

1       What is it in infrastructure or the point in  
2       time in which the regionalization that has  
3       prevented that from coming about?

4               And I think that will take us a  
5       long way while we have you all together in  
6       getting your reactions and take advantage of  
7       the dynamic communication.

8               So I think your homework for  
9       tonight is to think about everything that was  
10      talked about, think -- kind of mentally  
11      prepare for your work group tomorrow. We  
12      really do want to get as much as we can out of  
13      those domains tomorrow, so that we can turn  
14      another draft around for all of you to react  
15      to.

16              And then these questions about the  
17      reasons why we don't have measures where we  
18      need them. What measures do we have now that  
19      could adjust? And what is working right now  
20      and should be encouraged to continue to work?  
21      That's it.

22              CO-CHAIR KELLERMANN: Thank you.

1 With that, we will adjourn for the day.

2 MS. TURBYVILLE: Oh --

3 CO-CHAIR KELLERMANN: Oh, what?

4 MS. TURBYVILLE: We're not going  
5 to adjourn. Well, we can close the public  
6 comment.

7 CO-CHAIR KELLERMANN: Okay.

8 MS. TURBYVILLE: But we do want to  
9 -- I'm going to hand --

10 CO-CHAIR KELLERMANN: Executive  
11 session.

12 MS. TURBYVILLE: Yes.

13 CO-CHAIR KELLERMANN: Excuse me.

14 MS. TURBYVILLE: Yes. I'm going  
15 to hand it over to give us an update on those  
16 of you who want to have dinner with your  
17 colleagues, et cetera.

18 (Whereupon, the above-entitled  
19 matter was adjourned at 4:06 p.m.)

20  
21  
22



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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Regionalized Emergency Medical  
Care Services Steering Committee

Before: NQF

Date: 05-23-11

Place: Arlington, VA

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