NATIONAL QUALITY FORUM

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REGIONALIZED EMERGENCY MEDICAL CARE SERVICES STEERING COMMITTEE

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TUESDAY

MAY 24, 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 8:30 a.m., Andrew Roszak, Co-Chair, presiding.

PRESENT:

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

NQF STAFF:

ERIC COLCHAMIRO, MPA
LAURA RICHIE
SALLY TURBYVILLE, MA, MS

ALSO PRESENT:

CHARLES CAIRNS, MD, FACEP, UNC-Chapel Hill
CYNTHIA HANSEN, Office of the Assistant
Secretary for Preparedness and Response
GREGG MARGOLIS, Office of the Assistant
Secretary for Preparedness and Response
JOE MORRIS, DHS-Office of Health Affairs
MIKE RAPP, Centers for Medicare and Medicaid
Services
TINA TURGEL, RN, Health Resources and Services
Administration
JEFF WILLIAMS, MD, UNC-Chapel Hill

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

2 8:44 a.m.

3 CO-CHAIR ROSZAK: Good morning,

4 everybody. Thank you all for coming back for

5 another fun filled day, and hello to everybody

6 listening on the phone.

7 We are going to kind of juggle the

8 schedule a little bit today. We do have some

9 things to get to, but I think we've got a

10 little bit of time built in. So we should be

11 pretty good to go.

12 I just wanted to kind of recap the

13 day yesterday and see if anybody had any

14 thoughts or comments. I know we had a chance

15 to reflect a little bit on the activities last

16 night.

17 So how is everybody feeling today

18 about the work that was done yesterday? Any

19 comments? Any outstanding issues we need to

20 address? Rick, you got something? We kept

21 the UNC folks working hard last night, and we

22 are going to get to some of their revisions

1 and such in a moment here.

2 Anything else that's outstanding

3 issues? Rick?

4 DR. MARTINEZ: Yes, two things. I

5 thought you all did a great job yesterday. I

6 thought the panel did a great job.

7 I wanted to do one clarification,

8 and then make a little comment back on part of

9 our conversation yesterday.

10 You know, I realize that sometimes

11 when I engage in hyperbole about how much I

12 hate patient satisfaction, maybe you get the

13 wrong impression. I actually think it is

14 quite, quite important -- quite important, and

15 it is a good indicator of our doctor-patient

16 relationship. But I want to tell you, to

17 clarify my comments, because it goes back to

18 our comments yesterday, I actually believe it

19 has created, a lot like Art said, too much

20 focus on the wrong thing, because it is a

21 trailing indicator.

22 So the best people can't do well

1 in a bad system. So if your system is the
2 problem and what you do is you tell the staff,
3 don't forget to be nice, make some nice
4 comments, you know, give a cookie, then you
5 are really not fixing the problem.
6 So it goes back to this discussion
7 about patient centered outcomes versus patient
8 centered processes. A system is nothing more
9 than a collection of processes and, if those
10 processes are not patient centered -- and I
11 think, you know, trauma is a good example
12 where the resources are delivered to meet the
13 needs of the patient; STEMI is a good example
14 where the resources have been redesigned to
15 meet the needs -- then we are not going to
16 have -- we are not doing the right thing.
17 So I would actually urge we go
18 back and put in not just patient centered
19 outcomes, but patient centered systems or
20 processes, because those processes are what is
21 driving the outcomes we want.
22 CO-CHAIR ROSZAK: Would that be a

1 guiding principle, do you think?
2 DR. MARTINEZ: Under the guiding
3 principles, yes, I would like us to go back
4 and make a point of that is really the issue.
5 I mean, I got to sit there. I get a lot of --
6 I had 100-some hospitals. They come in.
7 someone has got bad patient satisfaction. You
8 go in there, and what you realize is the
9 waiting room times are an hour and a half or
10 three hours or five hours, and then what they
11 are doing is they are focusing on what are
12 they going to do to make the doctors and
13 nurses, make the patients happier.
14 Well, the process is wrong. So I
15 just want to make sure we understand there is
16 a difference there.
17 CO-CHAIR ROSZAK: That is a very
18 good point. I was looking back last night
19 over the guiding principles, and I just wanted
20 to make sure that the group felt comfortable.
21 Kind of building off of what you
22 were saying, Rick, I know we talked a great

1 deal at the IOM and then out in Phoenix about,
2 you know, regionalization is not
3 centralization.
4 I think we have captured that
5 point very well in the guiding principles, but
6 also this concept that Christie kind of
7 alluded to yesterday where, you know, it is
8 not necessarily always moving the patient. We
9 can move the knowledge. We can move the
10 resources. We can move the expertise through
11 a lot of these innovative mechanisms that are
12 out there now.
13 Kind of looking back through our
14 guiding principles, I don't know that that is
15 really expressed as much as maybe it should
16 be, and welcome your comments on that, but I
17 think it kind of goes to the point that you
18 were making.
19 DR. MARTINEZ: I agree with you.
20 You quoted it well, that it is about getting
21 the resources to the patient in the right
22 place at the right time.

1 I have never transferred a patient
2 to poison control, but I call them, and they
3 follow the patient, and there is limited
4 knowledge to the bedside with a plain old
5 phone, and I don't think people -- That is why
6 I told you earlier, I am not a big fan of the
7 word regionalization, not because it is not a
8 good issue, but because in our mind we threw
9 it into the old model. So sometimes we got to
10 find a way to show that new model. So maybe we
11 need to be explicit.
12 CO-CHAIR ROSZAK: Any other
13 thoughts or comments on the discussion
14 yesterday, guiding principles, anything you
15 would like to add or omit? Okay, very good.
16 So just kind of an overview of
17 what we are going to do today: As we talked
18 about yesterday, we are going to break into
19 small groups, and we will do that for
20 approximately an hour, and like I said, these
21 times are a little bit kind of loose this
22 morning, but around 9:00 or 9:30, somewhere in

1 that time frame, we will break into the small
2 groups. Eric will fill us in more on the
3 details of that.
4 So we will talk in small groups
5 for about an hour, and then we will reconvene
6 as a whole group and kind of put some stuff up
7 on the screen, and we've got easels in the
8 room for the small groups to utilize, to
9 really look at the buckets, the domains and
10 then some of the items that actually go into
11 those buckets to help look at a whole picture
12 of a regionalized emergency care system.
13 So that should take us almost
14 until Noon. We will do the lunch break. We
15 will come back around one o'clock and recap
16 the priorities for the second draft. There
17 was a little confusion yesterday. So I just
18 want to make sure we are all clear.
19 The charge from the committee back
20 to UNC will be the second draft of the
21 framework. The environmental scan is done,
22 and it is a background document. It is a

1 resource for us to use, but we won't be making
2 any substantial edits to that document. We
3 will be looking to redraft the framework with
4 all the hard work that we have done in the
5 last two days.
6 So we will go through that and
7 give the charge to UNC. Then we will do the
8 member and public comments, and then we will
9 just briefly discuss the summary and next
10 steps. So like yesterday, the timeline is
11 pretty tight. So we just review that to make
12 sure everybody is on the same page. Yes, sir?
13 DR. COOPER: Andy, forgive me for
14 not bringing this up two minutes earlier, but
15 I was still sort of forming my thoughts.
16 I think one thing that we have not
17 touched on, and one huge elephant in the room
18 in terms of emergency services, is the obvious
19 fact that emergency care, and particularly
20 resuscitation, really begins in the field with
21 a workforce that is widely varied in terms of
22 its skill level, preparation, and source of

1 compensation; that is to say, a huge number of
2 volunteers who are large on heart, but not
3 necessarily always perfect in terms of
4 execution.
5 We all know that the first few
6 moments of care in the emergency care system
7 are largely what make the difference. We can
8 have a tertiary quaternary level ICU care all
9 we want, but if we haven't begun the
10 resuscitation in an effective and timely
11 manner and transported the patient to
12 definitive care, whether that care begins in
13 a community level hospital or in an academic
14 center, the outcomes are not going to be good.
15 As we think through the issues of
16 quality standards, I think that a huge -- a
17 huge opportunity for improvement really exists
18 in the pre-hospital realm where quality
19 improvement efforts, as you know, have been
20 hit or miss, despite the valiant efforts of
21 huge number of people -- you know, Tommy
22 Loyacono among them -- and I am not exactly

1 sure how a group like the NQF could begin to
2 influence the development of true quality
3 improvement in the field, but I think it is a
4 nut that has to be cracked, if we are going to
5 make significant progress in terms of
6 improving the quality of emergency care
7 nationwide.
8 CO-CHAIR ROSZAK: I think that is
9 a great point, Art. You know, hopefully,
10 this framework -- when we are setting it up,
11 we can take some of those issues into account,
12 look at standardized curriculum and training
13 and some of the issues that Nick kind of
14 alluded to yesterday. But I completely agree
15 with you.
16 Being a field provider myself, it
17 is very hit or miss, and looking back from
18 where we were in the 1960s all the way to
19 today, it is a little bit amazing we are not
20 kind of further down the path. Skip?
21 MR. KIRKWOOD: I think, when we
22 look at the out of hospital component of the

1 emergency care system, the discussion
2 frequently goes toward exactly where Dr.
3 Cooper went, and talks about the large amount
4 of the land mass of the United States that is
5 served by volunteers. But I don't think we
6 should let that serve as an obstacle, because
7 if you look at it differently and look at who
8 the majority of out of hospital patients are,
9 you would probably find, if anybody ever did
10 the study which, like so much of out of
11 hospital stuff, is not adequately studied,
12 that most of the patients are actually touched
13 by full time career personnel of some sort or
14 other, because they are in major metropolitan
15 and heavily populated areas.
16 Two areas where this group might
17 make some contribution to pushing the pre-
18 hospital care world along is in the use of
19 technology and getting the out of hospital
20 care system from the very beginning linked
21 into the health care information system that
22 is going to grow over the next many years.

1 While we ought always to try and
2 focus on outcome measures, those are
3 impossible if you don't have intelligent
4 processes built. So we may want to look at
5 some process measures in the out of hospital
6 world to look at intermediate steps of
7 performance of the EMS systems in communities.
8 We can't get to a good outcome at
9 the end of the hospital stay without a good
10 EMS system, but we don't quite know
11 scientifically what that means yet, and some
12 process measures could help push it there.
13 CO-CHAIR ROSZAK: Those are all
14 good points, and I certainly think there is
15 room in our domain for our Care coordination
16 to really look at those issues about is the
17 pre-hospital medical record actually
18 integrated into the in-hospital medical record
19 and, if so, great; if not, why not?
20 I kind of agree with you in some
21 degrees about the standard of care, and I know
22 we struggled with this at the National Fire

1 Protection Association when we did the 1910
2 and 1920 and all those standards.
3 So I think this group does have to
4 do a little reflection and, really at the end
5 of the day, is a paramedic in Chicago the same
6 as a paramedic in rural Montana? Should you
7 be provided the same level of care?
8 Like it or not, there is great
9 variation across this nation, and I don't know
10 that we are going to fix that in this room
11 today, but are we at a point now where a nurse
12 should be a nurse, a doctor should be a
13 doctor, and a paramedic should be a paramedic?
14 I think in the pre-hospital
15 environment, as we have seen across all the
16 states, it is not necessarily comparing apples
17 to apples all the time. I think there might
18 be some opportunities here to at least address
19 that. Tom?
20 MR. LOYACONO: To follow what Skip
21 is saying, too, when we talk about record
22 linkage, you think about the pre-hospital

1 record; but in a lot of systems, the pre-
2 hospital component is not a single entity as
3 well.
4 I know in my own system we have
5 fairly good linkage between the EMS component
6 where the paramedics are and the hospital, and
7 being able to get those records together. But
8 there is no reflection of the first response
9 system at all. The fire department goes out
10 first. Are they part of the system? They are
11 getting there first. They are getting someone
12 an EMT on the scene before anybody else is.
13 Largely, what they are doing and what they are
14 accomplishing is not recorded at all, because
15 they are handing it off to my system, who --
16 that is where the record begins. I think we
17 are missing a huge amount of data there.
18 CO-CHAIR ROSZAK: And, Tim, as you
19 know, a lot of times those first responders
20 don't get paid. So that even furthers the
21 problem of, well, why are we documenting this
22 if we are not going to get reimbursed. We

1 could spend a whole three-day session on that,
2 I am sure.
3 MR. LOYACONO: Well, yes, and when
4 you bring that up, the system that requires
5 transport for pay -- and I know we have all
6 heard this in many, many meetings over the
7 years -- and when we talk about bringing
8 technology into the field and telemedicine and
9 those things, there are many things that the
10 pre-hospital system can do to move patients
11 more efficiently, in some cases past the
12 emergency room directly to a cath lab,
13 something like that.
14 A lot of times, there is an
15 opportunity to fix a problem and bypass the
16 hospital entirely by putting them into the
17 primary care arena, take care of their problem
18 on site and refer them to somewhere other than
19 an emergency room. But all these things are
20 going to take the technology and the
21 connections, and there is going to have to be
22 a funding mechanism so that I can be paid for

1 providing the service. The physician or
2 intermediate provider on the other end is able
3 to be compensated and protected for their role
4 in it.
5 You are right. We could talk
6 about that all day.
7 CO-CHAIR ROSZAK: Nick?
8 MR. NUDELL: I would like to add
9 to my distinct colleagues -- distinguished
10 colleagues, excuse me.
11 The pre-hospital care record
12 begins before they see EMS. It begins with
13 the EMD dispatch call triage steps, and there
14 is quite a lot of data that is collected at
15 that point in time and stored and recorded.
16 But by and large, it is not used for outcomes
17 or patient evaluations or tying back in
18 initial presentation over the phone to the
19 care that was received in the pathway.
20 So I think it would be -- We would
21 be well served to bring that link as early
22 into the chain as possible.

1 My second comment was about Dr.
2 Cooper's comments. I appreciate what he had
3 to say about the pre-hospital arena. There
4 are many areas of the country, geographically
5 large, where the ambulance services have no
6 quality assurance, no quality improvement
7 activities taking place, and their main focus
8 in quality is just making sure an ambulance
9 responds.
10 So they are at such rudimentary
11 levels of quality improvement or quality
12 management that a lot of this will be right
13 over their heads, because it is not where
14 their planning and thinking is.
15 So I think that we would be well
16 served to make sure that the draft speaks to
17 their needs and provides some mechanism to
18 help bring them into it.
19 CO-CHAIR ROSZAK: Those are
20 really, really good points, and before I came
21 here, I actually graduated high school in a
22 small rural town with 24 other kids. So I

1 have lived the rural life and could definitely
2 appreciate just trying to get the ambulance
3 out the door at three in the morning. A very
4 good point, very well taken.
5 Nick and Gary and Tom, you know,
6 and a few of our other folks with rural
7 experience to make sure that we are not going
8 too off track in that. Mike?
9 DR. SAYRE: I just want to provide
10 a little slightly different view. To me, the
11 whole genius of this approach and why we are
12 here today is it has got the opportunity to
13 kind of turn that system around. So what I am
14 hearing a lot is a sort of top-down approach:
15 We need to improve training.
16 Really, what we are talking about
17 is more of a bottom-up approach here, to
18 actually measure stuff, and you get different
19 people engaged then who then start to pay
20 attention.
21 So in the local community, if the
22 pre-hospital care is bad, then the hospital's

1 quality measures aren't going to look very
2 good in that regionalized system, and they are
3 going to get interested in wanting to make it
4 better. That is going to really, I think,
5 make a huge difference, and different
6 communities are going to solve that problem in
7 different ways.
8 Some places may choose, say, not
9 to have paramedics at all, because it just
10 isn't a good way to use their resources. I
11 think that we would be wise to not be too
12 prescriptive about that and rather to let
13 various communities figure that problem out
14 for themselves. There is plenty of resources
15 about how to do that.
16 CO-CHAIR ROSZAK: Good point, good
17 point. Dr. Cooper?
18 DR. COOPER: Very briefly, I
19 raised the issue, because I fundamentally
20 agree with Mike. I think the question for us
21 here is how can a group like the NQF
22 creatively address this problem through

1 creation of a benchmark that -- or suggestion
2 of a benchmark, a creation of a platform for
3 a benchmark, so to speak, that will begin to
4 address some of these issues and give some of
5 those local communities a direction in which
6 to go to help figure out what the next steps
7 are.
8 It is a tall order, given the
9 disparate nature of that system, but as Mike
10 has said, every community will solve it in a
11 different way, but some direction in terms of
12 a benchmark toward which -- or benchmarks
13 toward which the initial critical component of
14 emergency care can go will be very helpful.
15 CO-CHAIR ROSZAK: Thank you very
16 much. I did want to just compliment everybody
17 on your engagement yesterday. I did find it
18 very fascinating that everyone around the room
19 actually spoke up. I know we are not a shy
20 group. So it wasn't that much of a shock, but
21 I do appreciate your feedback. Ron?
22 DR. MAIER: I will just add to

1 what Art was saying, though. I think, if it
2 is going to work which as we heard, it has
3 been a long time -- you know, the late
4 Sixties, 50 years, and we haven't made much of
5 a dent in this problem.
6 In addition to benchmarks, because
7 I think it should go from the ground up, is
8 just to provide and ensure the joint
9 accountability that we were talking about
10 yesterday. That is something that has really
11 been missing from the program, is that the
12 hospitals have been able to disassociate
13 themselves from having to work with the pre-
14 hospital providers, because that joint account
15 has never been in the system before. I think,
16 without that component, it is still going to
17 be very difficult to get the changes that we
18 need to have made.
19 CO-CHAIR ROSZAK: Good point.
20 Skip?
21 MR. KIRKWOOD: I would like to
22 explore this, do it from the ground up, and

1 let every community find its own way just a
2 little bit, because that seems quite different
3 from the way the rest of health care is
4 approached.
5 When we hit the hospital door, we
6 start dealing with National Consensus
7 Standards. We start dealing with strong
8 centralized regulation and requirements from
9 CMS, and I am wondering why our colleagues
10 think that the pre-hospital community should
11 be held to standards that are homegrown or not
12 at all or something.
13 DR. SAYRE: Good point. I think
14 the issue isn't -- those of us who work in
15 hospitals maybe do not agree, but I think most
16 of them would -- that this top down approach
17 of imposing standards doesn't really actually
18 result in improved quality, which is sort of
19 why the National Quality Forum exists, because
20 we went for many, many years with saying,
21 well, if you just had this and that and the
22 other thing, then patients are going to get

1 great care, and it is not about that.

2 It is about actually holding

3 people accountable for the kind of care that

4 they deliver, and when -- As Dr. Martinez

5 pointed out yesterday, I, too, remember making

6 many phone calls trying to get some

7 cardiologist interested in taking care of a

8 STEMI patient, and it was like, oh, no, you

9 know, got a golf date, whatever, can't do

10 that; and suddenly, within one month, the idea

11 that the hospital was going to look bad in the

12 local paper because their door to balloon time

13 wasn't good -- problem solved.

14 Just making them accountable for

15 the actual outcomes for the patients where a

16 process measure that was tightly linked to

17 outcomes --

18 MR. KIRKWOOD: I am not

19 disagreeing with that, but --

20 DR. SAYRE: But they didn't tell

21 us how to solve that problem. They didn't

22 say, well, you need to have pre-hospital 12

1 lead, and you need to have this, and you need
2 to have that.
3 MR. KIRKWOOD: But they told you
4 that the problem needed to be solved.
5 DR. SAYRE: Right.
6 MR. KIRKWOOD: You know, I think I
7 watched the same changes in behavior that you
8 did, and it came right after the announcement
9 came out that CMS or somebody else was going
10 to publish exactly that performance, and that
11 was -- From my view, that was an externally
12 imposed top down performance standard, you
13 will do this. It wasn't something that
14 somebody invented locally and decided this was
15 a great way to do it.
16 DR. SAYRE: Sure, but they didn't
17 tell us like how many interventional
18 cardiologists we had to have.
19 MR. KIRKWOOD: No.
20 CO-CHAIR ROSZAK: I think there is
21 kind of a fine line there between identifying
22 the issue and bringing attention to it versus

1 being so prescriptive that you have to have 12
2 ambulances staffed by three paramedics or
3 whatever. So we have to be mindful of those
4 as we proceed today, but I think both sides
5 kind of have merit there.
6 Any other comment as we begin to
7 get into our small groups? I am going to turn
8 it over to Sally for some introductory
9 remarks, and then we are going to talk about
10 the domains again with UNC.
11 MS. TURBYVILLE: First off, I
12 apologize. I think I have been late for three
13 meetings, but I don't know what happens in
14 this area when it starts to rain, but people
15 lose their minds. So I have gotten stuck
16 trying to get here, took much longer. It is
17 usually only a 10-minute trip for me. So I
18 apologize to all of you.
19 I did hear a lot of comments
20 yesterday and some real important common
21 themes, at least I thought. I wanted to
22 bounce them off of all of you and give you an

1 opportunity to react to some of the notes that
2 I jotted down.
3 I heard a call for us to make sure
4 we are explicitly incorporating the concept of
5 population health. I think all of you
6 understand that it is there, but making sure,
7 as we reach out to a broader audience, that we
8 are being very explicit about that.
9 Acknowledging that emergency care
10 is part of the entire health care system and
11 that we can't necessarily make huge strides in
12 making it effective and efficient if the rest
13 of the health care system is not as well. So
14 I don't think there was a call for us to
15 change any of our approaches, but to make sure
16 that we are acknowledging that that is true.
17 A call for leadership, a need for
18 national and local leadership to keep these
19 types of improvements moving.
20 I also heard an interesting
21 discussion about looking at the model and
22 that, with emergency care, that we think about

1 that Phase 3 in the episode of care and loop
2 back into the community or the population
3 health. I thought that was a very important
4 and interesting concept that came out of this
5 group.
6 Then I think the more blunt
7 comment was the call for us to add a new
8 domain. It has been called the sixth domain,
9 but actually, I think it is the new first
10 domain around access and capacity.
11 So I think we walked away
12 yesterday with a lot of really important
13 changes to our approach and the document, and
14 really appreciate the thoughtfulness. We are
15 very excited that we have gotten this far in
16 just one day, and we are really looking
17 forward today to kicking around the domains
18 that we have and improving them and making
19 sure that we have the domains and subdomains
20 as they should be.
21 So again, to echo Andy's comments,
22 yesterday was fantastic. I really heard a lot

1 of important contributions and updates that we
2 need to make, and we are really looking
3 forward to doing that, and I know that Jeff
4 and Chuck have already been working on
5 revising some of the definitions and updating
6 the guiding principles, but I think we came to
7 a really good point yesterday with a lot of
8 agreement of what we still need to do with the
9 framework.
10 CO-CHAIR ROSZAK: So if we are
11 ready, we can begin the roast of Chuck, Day 2.
12 Poor guy went up and soaked in the bathtub --
13 we beat him up so bad yesterday.
14 As you know, Chuck, none of this
15 is personal. You know that. We are all
16 having fun. So I believe you guys have
17 revised some definitions, and then we will
18 talk about some of the domains, and provide a
19 little recap of yesterday from your
20 perspective. So I will turn it over to you
21 guys.
22 DR. CAIRNS: So, thank you all

1 again. No, actually, we found the session
2 very productive yesterday. It reflected a
3 little bit of the evolution that we hadn't
4 thought as we have been interacting with NQF
5 and understanding the development of measures.
6 Frankly, I thought it was really extraordinary
7 kind of insights into how both emergency care
8 is perceived, how it can be measured, and how
9 we think of it as a system, especially in this
10 regionalized context. So I thought it was
11 very valuable.
12 So two charges this morning: The
13 first one was to go over some revised
14 definitions, and I thank Jeff yet again for
15 extraordinary work on this. The second one is
16 to introduce this new domain. So let's start
17 with the definitions.
18 So in this case, we've got
19 regionalization and regionalization of
20 emergency care services, and taking Dr.
21 Maier's suggestions and comments, we are
22 really just going to collapse them.

1 So the first comment is we are
2 going to look at regionalization, and then we
3 are going to look at this key definition of
4 regionalized emergency medical care services
5 as an inclusive term, and then I guess the
6 question is what should be key? What should
7 be key definitions? What should be glossary
8 terms?
9 The idea here is that in most of
10 the NQF frameworks, there are key definitions
11 as a component to the report, but we heard the
12 valuable suggestion yesterday to include a
13 glossary of terms. Clearly, I think that
14 units of service, centralization -- there were
15 a number of other medical specific terms, ED
16 overcrowding, Kathy, that I heard, boarding.
17 DR. RINNERT: Boarding, crowding,
18 offloading.
19 DR. CAIRNS: I think that anything
20 that is specialty specific or kind of used in
21 a jargon or this kind of vernacular really
22 needs to be defined. Sir?

1 DR. MARTINEZ: What happens to
2 systems of care? Did we decide? I mean,
3 Kelly is not here. So we can do what we want
4 today.
5 DR. CAIRNS: That is fair enough.
6 So, Rick, we put them altogether. If you
7 think there would be value in keeping it
8 separate as a system of care, we certainly
9 could.
10 DR. MARTINEZ: I thought yesterday
11 it was a separate issue, only because it went
12 into greater detail of what it is. It is a
13 collection of processes, blah, blah, blah, and
14 I thought it built it out. But I don't care.
15 I just didn't see it disappearing yesterday.
16 That's all.
17 DR. CAIRNS: How about this, Rick?
18 We put up the proposed key definition of
19 regionalized emergency medical care services
20 and see the complements or opportunities for
21 extension to a systems of care definition?
22 DR. MARTINEZ: I just -- The

1 committee can correct me on that. I don't
2 recall us getting rid of that. We've rolled
3 some things up. Was that the issue, was to
4 roll all that into one definition? Is that
5 it? Is that the proposal?
6 DR. CAIRNS: That was certainly
7 the post-meeting discussion that we had with
8 our colleagues.
9 CO-CHAIR ROSZAK: Yes. I don't
10 think that we ever actually fully resolved the
11 issue. I know some were leaning toward
12 eliminating it, and some were kind of leaning
13 toward keeping it in. So I think they have
14 done a good job at revamping and reworking
15 some of these.
16 So maybe we should just see what
17 we have here before we get too far.
18 DR. MAIER: Well, before you go
19 too far, though, I agree. I thought we were
20 going to -- Since the verbiage of
21 regionalization and system are virtually the
22 same, I thought you were just going to

1 collapse them, but you changed it to services
2 from system.
3 DR. CAIRNS: Ron, I think we would
4 like to just see what these definitions are,
5 and then we can go back and clarify the
6 moniker after we see the definition. Is that
7 fair enough?
8 CO-CHAIR ROSZAK: Skip?
9 MR. KIRKWOOD: While we are
10 painfully wordsmithing, I think it is wise to
11 keep the system or whatever we are talking
12 about in the plural, because if you go -- if
13 you move to the singular, then you are talking
14 about at least the flavor of centralization or
15 central authority or something, which I think
16 we are trying not to do.
17 DR. CAIRNS: Great point, Skip.
18 You know, we played around with system versus
19 systems in multiple aspects of the document,
20 and I think that is why it would be valuable
21 to at least go over these definitions and see
22 where we are and where find intersection with

1 yesterday's and where we will bring them back.
2 MR. KIRKWOOD: I know in greater
3 Raleigh this week, the fight is over whether
4 there will be one system or two systems. So
5 very timely as the SCUDs fly back and forth
6 between Chapel Hill and Raleigh.
7 DR. CAIRNS: Well, one thing,
8 though, is that, clearly, you can have an
9 overriding system on a modeling perspective,
10 and you could have a system of systems as part
11 of that technical model.
12 DR. RINNERT: Chuck, one of the
13 other things that we talked about yesterday
14 that I don't know if it was properly captured,
15 and it didn't have to do with terms and
16 definitions, but it had to do with more of a
17 concept of sort of describing the milieu in
18 which health care would be occurring.
19 John did that quite -- I think it
20 was John that brought up the idea of the
21 horizontal elements and the vertical elements
22 in a system or set of systems that overlap.

1 Along the horizontal axis is sort of the
2 baseline regional kinds of concepts that you
3 would have, with everyone having at least a
4 certain minimum level of care that is provided
5 or competence, and then going toward the
6 thought of the vertical elements allowing more
7 subspecialized and very beefy tertiary kinds
8 of care, and how the patient would work
9 through the system, both on a horizontal and
10 in a vertical sense.
11 Sally sort of talked about it,
12 saying that we would want to have arms where
13 we were more beefy in exactly what the patient
14 would be getting, and then arms that maybe are
15 a little more rudimentary in describing what
16 would be the basics that everyone would need
17 to provide. Depending on the level of
18 expertise that the patient needs, they would
19 move both horizontally and vertically within
20 the system.
21 I think it was John's concepts, if
22 I am not mistaken, but I think as an

1 overarching sort of planning principle or a
2 concept for how patients would move
3 horizontally and vertically within the system
4 depended upon what their individual needs
5 would be and whether they would be cared for
6 in the regional or in a horizontal basis or
7 have to seek a more higher level of care
8 within the vertical axis would be something
9 you could grid out.
10 DR. CAIRNS: Thank you, Kathy. In
11 fact, I think that one of the ways we talked
12 about illustrating that would be to have a
13 generic episode of care for regionalized
14 emergency medical services and incorporate the
15 Phase 1 components that are basic to all
16 regionalized medical care services, the Phase
17 2 components, the Phase 3.
18 Frankly, I like the split to a
19 Phase 4. So a phase 3 would be in hospital.
20 A phase 4 would be outside. I think that was
21 Dr. Carr. I think that having that across the
22 various generic episode of care for

1 regionalized emergency medical services, I
2 think, would be the way to illustrate that
3 concept.
4 That would then allow for
5 conditions specific, whether that is symptom
6 based or whether that is disease based
7 episodes, to then be generated for more
8 directed conditions.
9 DR. RINNERT: Right, because
10 obviously, the fidelity of what resources are
11 brought to bear on that patient are dependent
12 upon the expertise that is looking at that.
13 So you would have, you know, symptoms or chief
14 complaints along sort of the basic level, and
15 then as you get more and more information
16 about that patient, whether it is through
17 testing or more sophisticated examiners
18 looking at this patient, you then would be
19 getting a beefier sort of snapshot of what is
20 going on with them, and what are the exact
21 treatments that need to be brought to bear on
22 that patient.

1 So even this level of
2 sophistication of the people that are
3 interacting with that particular patient would
4 be very variable, dependent upon what
5 information you had at hand. Sometimes it is
6 just the dispatcher asking a bystander, is the
7 patient breathing. Those are sort of very
8 basic kinds of interactions that allow you to
9 gain some data, and then move the patient
10 further down the continuum.
11 DR. CAIRNS: So one thing that we
12 could think about, Sally, and this would just
13 be a question maybe on the episode of care
14 model, is: You have a Phase 1. Phase 2 is
15 where the episode begins. Phase 2 could
16 either have different units of service, like
17 pre-hospital which could even be split into
18 community response versus EMS response; then
19 emergency department response.
20 In our model, Phase 2 also could
21 include acute care areas of hospitals, and
22 then a Phase 3 would be in-hospital specialty

1 care or to transfer to a definitive care
2 facility if the patient were transferred.
3 Then Phase 4 would be post-
4 hospital care, potentially interventions or
5 prevention and rehabilitation and things.
6 Is it better, you think, to
7 continue the phases out and say, okay, Phase
8 1 is pre-episodic care. The first phase is
9 literally kind of in the sequence, so
10 community response and EMS, emergency
11 department, hospital, post-hospital; or are
12 we getting too many phases?
13 MS. TURBYVILLE: I think that it
14 is definitely intriguing. The other question,
15 though, is at what point do they go get
16 integrated back into Phase 1. So I wonder if
17 this idea of Phase 4 isn't the component that
18 puts them back into Phase 1, which is the
19 population at risk, which is pretty much the
20 community, because anyone at a given time has
21 the potential to require emergency care, if I
22 am thinking about this right.

1 So I think it is important to
2 capture this piece. I am not so convinced
3 that it needs to be a Phase 4 versus part of
4 Phase 1, but clearly, all of you have that
5 contribution.
6 So I don't think -- We don't want
7 to limit the thinking of the group to this
8 episode based model. It is meant to be
9 something to spur you into how the model will
10 work. So I think we should play around with
11 it.
12 DR. CAIRNS: So just one quick
13 response. I see John's. I see a number of
14 cards going up. So I would modify it based on
15 that comment, that maybe Phase 1 -- Phase 1 is
16 going to have a loop to a Phase 4.
17 Number 2, Phase 2 could be -- A
18 potential Phase 2 would be the out of hospital
19 component. Phase 3 would be the in hospital
20 component, and Phase 4 would be the post-
21 hospital care.
22 MS. TURBYVILLE: Phase 2 in the

1 traditional part of it is where the condition
2 is identified. Right?
3 DR. CAIRNS: Fair enough. So we
4 should collapse still the units of service of
5 out of hospital and emergency department care
6 still in Phase 2. Phase 3 could be this
7 hospital based, and then the question is, is
8 it a Phase 4 or is it a stratified Phase
9 4/Phase 1?
10 MS. TURBYVILLE: And I wonder if
11 it is really not trajectories that are coming
12 out of the phases, whether or not we need a
13 Phase 4 or not, because do all emergency
14 situations end up going into the acuity --
15 into an acute hospital setting or can some not
16 be resolved in the emergency department.
17 So I think the phases are -- when
18 we have the potential for it to be resolved in
19 different ways, maybe those are trajectories
20 off of the model versus the actual Phase 3
21 that someone may or may not. But I think we
22 can play around with it.

1 DR. CAIRNS: No, I hear your
2 point. I like that.
3 MS. TURBYVILLE: And I am not
4 saying no. I just think that we are right to
5 think about how this model applies.
6 DR. CAIRNS: So just for the
7 benefit of the group: So what we are talking
8 about, it is in one of the model episode of
9 care frameworks, severity will determine a
10 trajectory out of Phase 2. If I hear you
11 correctly, this would be an opportunity.
12 So one of the trajectories would
13 lead to acute hospitalization or transfer or
14 some other event. Another part of the
15 trajectory could be to -- well, yes, but then,
16 unfortunately, you don't have to worry about
17 the episode of care.
18 MS. TURBYVILLE: Or it is Phase 3.
19 I mean, I just want to push it a little bit.
20 I think we should kick it around. I don't
21 know -- It is kind of hard to --
22 DR. CAIRNS: Fair enough. Well,

1 we could put together this graphic based on
2 these concepts, Kathy, to incorporate the
3 discussion that various units of service are
4 going to have different levels of information
5 and different levels of interventions that
6 would be important, but that the overall theme
7 of integration across those services,
8 including communication, including
9 disposition, including integrating the care
10 that is available across those different units
11 for an episode of care will be important
12 components of any generic episode of care.
13 DR. RINNERT: We always want to
14 remember, and we don't have the little picture
15 up there, but at any point in the system,
16 whether the patient is in Phase 1, 2 or 3, if
17 someone dies or if someone gets better or
18 there was a misdiagnosis and the patient got
19 sent home, whether that was right or wrong,
20 those are sentinel -- in my opinion, sentinel
21 events, and those are ones where you learn the
22 most about the system, and you learn the most

1 about your sophistication of care.
2 So we sort of dispense with them
3 and go, well, we really want to know about the
4 people that go all the way through, because we
5 think we learn the most. I would caution us
6 to make sure we have measures to look at the
7 people who fall out of that or don't ever --
8 maybe even the people that don't ever get
9 included from the outset.
10 DR. CAIRNS: Well, I think one of
11 the key components that illustrates that
12 concept is if we were to go to conditions like
13 symptom based care, and Jesse was bring that
14 up yesterday, that clearly not all people who
15 have chest pain are going to have acute
16 myocardial infarctions. In fact, the vast
17 majority won't.
18 So understanding that interaction
19 across an episode of care will be very
20 important, specifically if the performance
21 measures are linked to AMI and not to chest
22 pain. So understanding that dynamic will be

1 very important, because clearly, there would
2 b e resource utilization issues, cost,
3 capacity of the system and a lot of other
4 components that will come into play.
5 CO-CHAIR ROSZAK: Let's just go
6 around and knock off some of the comments, and
7 we will just work our way this way. Go ahead,
8 John.
9 DR. FILDES: Just a couple of
10 comments. One is that what Sally is
11 articulating very well, in fact, is the Public
12 Health model for the system of care for time
13 sensitive injury and illness. That is really
14 a drive-home message in the HRSA document of
15 2005, and these phases of care do match up
16 with this.
17 We talk about trauma systems, but
18 honestly, it is just a disease based system of
19 care for a time sensitive condition, and you
20 can just plug in any diagnosis you want on top
21 of it. But the requirements when we go out
22 and look at a system of care that deals with

1 injury as a time sensitive condition is that
2 you have to actually define the public health
3 and the population. You have to define the
4 epidemiology of the condition, in this case in
5 jury in the population.
6 You have to actually educate the
7 community about it. You have to have primary
8 and secondary prevention in position. You
9 have to have access to care through 911 and
10 dispatch of ground to air units. You have to
11 have a plan of where they are going to go, and
12 all that stuff really gets into Phase 1.
13 Then when the first provider
14 reaches them, then you actually begin Phase 2,
15 and that includes a variety of out of hospital
16 emergency medical personnel, and they
17 eventually get to a receiving area, which
18 could be a burn unit, an obstetrical unit, an
19 emergency department or whatever that happens
20 to be. Then they get maybe an operation, and
21 they might go to an ICU, and then you follow
22 them into the convalescent phase, which might

1 actually cross over to a Phase 3.
2 Then some of them go to rehab, and
3 some of them go to LTAC, and some of them go
4 home. At the end, there has to be a data
5 system to record their outcomes and to link
6 them back to --
7 DR. COOPER: The structure
8 response in Phase 1.
9 DR. FILDES: -- to Phase 1 to
10 mitigate that activity, going forward, and
11 modify the risks. That is really what the
12 discipline of the disease specific system of
13 care for injury has been doing since 1966, and
14 in a certain sense, I am trying to let this
15 unfold, because this is a creative process,
16 but you are recreating a wheel here. I hate
17 to say that, but you are recreating a wheel.
18 A lot of this terminology has
19 already been nailed down, and it is not just
20 in publication, but it is actually in
21 Congressional law and other sorts of things.
22 They call things systems. They don't call

1 them services.

2 So I'll stop there, and I have

3 emailed some important documents to important

4 people in the room, and I will come back

5 around and say some more things later.

6 DR. COOPER: I think John's

7 comments, of course, are right on the mark.

8 I agree with him completely. I will just add

9 two thoughts here.

10 I think, as we think about the

11 episode of care model, you know, Sally's

12 comments about how different patients may

13 follow different trajectories through the

14 model is absolutely correct. But when we are

15 talking about an individual patient, when we

16 are talking about individual health as opposed

17 to population health, we may be thinking about

18 a linear model. Okay? But when we are

19 talking about population health, we are really

20 talking about a cyclic model, in the sense

21 that Ron Maier just mentioned.

22 In other words, the data that we

1 gather or the aggregate data that we gather
2 from the experiences of several patients that
3 are going through that episode of care model
4 feeds back from the last phase to the first
5 phase, whatever number you are talking about.
6 In terms of performance
7 improvement, it is a big performance
8 improvement cycle. It is a PDCA cycle, you
9 know, if you want to think of it that way,
10 because the data is just going around and
11 around. So we are -- I mean, this is really
12 the chain of survival, only the aggregate data
13 from the chain of survival links back -- It
14 doesn't go out to infinity. It actually links
15 back on itself to the beginning, so that you
16 have the kind of feedback in terms of the
17 system and the risk modification that Ron
18 Maier was just talking about.
19 So I think, as we think about
20 episodes of care, we have to understand that
21 it is the aggregate experience of populations
22 who are obtaining those episodes of care that

1 link back and modify the entire system.
2 MR. KIRKWOOD: At the risk of
3 repeating myself, not every episode of care
4 that begins with a contact to a 911 center
5 needs to end up with the patient in a
6 hospital, but there are a number of other
7 trajectories, and I really -- I like the term,
8 but they don't all end one further step up the
9 health care system.
10 DR. MARTINEZ: Just a little
11 different, but build on the idea of making
12 sure that what we do builds on the past and
13 kind of strengthens it.
14 The one thing you mentioned
15 earlier, I am not sure we have incorporated
16 too much, but as we go to maybe the next steps
17 we are going to do is I think we need to be
18 mindful of the aims of quality, so that we put
19 things in those terms, in a way. A lot of
20 these measures we are talking about are
21 efficiency measures. They are measures on
22 timeliness, effectiveness, patient

1 centeredness, that sort of thing.
2 It is funny because, you know,
3 even things like equitable are going to come
4 out in the cost issue, winners and losers
5 within the system.
6 DR. CARR: The other piece that I
7 think we didn't make sure that we keep on the
8 radar is that we could draw this -- you know,
9 whether it is the HRSA trauma injury system
10 circle or the episodes of care, they are
11 pretty analogous, I think, in many ways.
12 I strongly think that we shouldn't
13 be drawing, as Sally mentioned yesterday, 14
14 of them for each of the domains of each
15 emergency care condition that we are willing
16 to regionalize.
17 I don't know how we get around
18 that. I mean, this is one of the pieces that
19 -- you know, trauma has got a long track
20 record of doing this, and we have now seen the
21 American Heart Association put out a call for
22 proposals for regionalized STEMI systems,

1 regionalized cardiac arrest systems,
2 regionalized stroke systems.
3 It is an interesting thing. It is
4 a parade of disease conditions, and I don't
5 want us to be stuck in this model where we
6 don't recognize the synergy that can happen
7 from learning from each other and building
8 pieces together.
9 MR. NUDELL: I put my flag up four
10 commenters ago. Where we were in the
11 discussion at that point in time was comparing
12 the Phase 3 and Phase 1 and how you
13 transition.
14 My thought at the time was that
15 doesn't really work for the community
16 paramedic model where the community paramedic
17 isn't serving the Phase 1 purpose. They are
18 serving the Phase 3 purpose where the episode
19 -- it is hard to define when the episode is
20 ending and when it is continuing or
21 restarting.
22 So I would just encourage us to be

1 mindful of that. Some of the work that the
2 community paramedics are doing is still
3 evolving, and it is still -- they are still
4 finding their way, but many of the things that
5 they are doing are preventing people from
6 coming back into Phase 1.
7 So having an allowance for that
8 would be good.
9 MR. LOYACONO: I wanted to expand
10 on Kathy's comment a little while ago. As we
11 look in communities, I think it is essential
12 that we be able to seek a way to find these
13 people that fall out of the system. I know an
14 EMS service, you know, you send a name on some
15 call, and for whatever reason the patient
16 stays home, and an hour later you are going
17 back out there, and they have had another
18 event.
19 They don't always go to the same
20 hospital either, and when you are making a
21 second run on a patient who has already been
22 in and out of a hospital and they've got some

1 event, and now I am not going there anymore,
2 don't take me there, there needs to be a way
3 to connect those people so that you can find
4 where the system failed and fix it. That is
5 a moving target, but I think it is terribly
6 important.
7 CO-CHAIR ROSZAK: These are all
8 great comments. In the interest of time, I
9 would like to get back to the definitions and
10 get that done. We are about 9:35 now. So,
11 Chuck, why don't we run through the
12 definitions. We will refresh on the domains,
13 and then we do need to get into our small
14 groups to keep on the schedule for today.
15 DR. CAIRNS: Very good, Andy. So
16 if you could just go to the next slide. So
17 here is regionalization. The key change is
18 the last line, "to a defined population of
19 patients."
20 So regionalization: The concept
21 of an established network of resources that
22 delivers specific care -- for example,

1 protocols, definitive procedures, higher care
2 levels or care pathways -- that is not
3 universally available in the out-of-hospital
4 setting -- for example, a physicians' office -
5 - or in some acute care hospitals to a defined
6 population of patients.
7 This is really per Art Kellerman's
8 suggestion yesterday, again keeping this
9 concept that regionalized care does not equal
10 centralized care.
11 This is now this kind of
12 amalgamation of definitions for regionalized
13 emergency medical care services. This is
14 going to just focus in on the services: A
15 deliberate and planned system of both in- and
16 out-of-hospital resources that delivers care
17 to a defined population of patients who have
18 conditions for which rapid diagnosis and early
19 intervention for acute illness or injury
20 improves patient outcomes.
21 A key change here, other than the
22 amalgamation, is the incorporation of Dr.

1 Carr's emergency conditions language.
2 A regionalized system of care may
3 exist to serve a particular geographic area,
4 patient population or disease condition. The
5 out-of-hospital component of regionalized
6 emergency medical care services may be
7 represented by the pre-hospital (i.e., field
8 EMS), recognition of a time sensitive
9 condition, an initiation of the system of
10 care, or could also be represented by the
11 transfer of a patient for specialty care
12 within a regionalized network.
13 This is new language now. "When
14 unscheduled episodic care of varying levels of
15 acuity is provided in both in-hospital and
16 out-of-hospital settings of regionalized
17 emergency medical care services, the focus of
18 this project is on measuring systems of care
19 for time critical, life threatening clinical
20 conditions. Nonetheless, the effectiveness
21 and capacity of regionalized emergency medical
22 care services systems is determined, at least

1 in part, by the system's ability to deliver
2 emergency care, while non-emergency care is
3 also provided to other patients."
4 So the key concepts addition there
5 were just these ideas of non-emergent care,
6 the fact that it will affect the performance
7 of emergency care, and to provide a context of
8 the system of care in which regional emergency
9 medical services are provided.
10 DR. PINES: The one comment I have
11 is a potential -- an amendment that we would -
12 - where we say life threatening, to put in
13 some language about potentially life
14 threatening. That would include chest pain
15 and acute myocardial infarction as what we are
16 trying to tackle. So we could focus also on
17 diagnostic centers to re-stratify along with
18 the patients who actually have AMI.
19 DR. CARR: I don't know what Art
20 said yesterday, but the language from the very
21 first definition of regionalization ends with
22 the word "patient." I don't know that that is

1 true. I think it is to a defined population.
2 I mean, they are potential patients until
3 something happens to them, and I think that is
4 important. I mean, to the population, they
5 think we are weird, because we call everybody
6 patients.
7 Then the second thing I wanted to
8 say is that in the emergency care sensitive
9 condition piece, that emergency care sensitive
10 condition isn't my language. That came from
11 my partners at AHRQ, because they were
12 mirroring something that already exists, which
13 is the ambulatory care sensitive conditions
14 that is recognized.
15 So if want to -- I am not wedded
16 to it, and clearly the committee should
17 decide, but if we want to draw the parallel to
18 ambulatory care sensitive conditions, we
19 should call them emergency care sensitive
20 conditions, not time sensitive, not emergency
21 care conditions. That is sort of the variants
22 that are mixed in here.

1 CO-CHAIR ROSZAK: Fair enough. I
2 guess we are trying to synthesize it into this
3 approach, though, for regionalization.
4 MR. LOYACONO: I hate
5 wordsmithing, but on the definition -- I think
6 it is the next one -- disease condition -- I
7 mean, you know, the care system is for a
8 geographic area or a patient population who
9 may have a specific disease condition. to me,
10 we are providing a system that treats people,
11 not disease.
12 DR. MAIER: To that specific
13 point, I think somebody brought the analogy of
14 like you got one hand surgeon. He defines his
15 population, because he is the only show in
16 town, and so it is totally disease driven.
17 DR. FILDES: My point was that it
18 was resource driven. So if you only have one
19 person around who can deliver a baby, then
20 that drives it to the resource.
21 MR. LOYACONO: Isn't it still the
22 person with the cut-off hand that we are

1 seeking to serve?

2 DR. PINES: My other comment, just
3 in general about a lot of this stuff, is I
4 think we all understand what this is, but I
5 can imagine showing this to someone who
6 doesn't really think a bit in this area, and
7 this language is, I think, very complex and is
8 very jargony.

9 I know we were talking about
10 having a glossary, but it may be helpful to
11 show some of this to someone who hasn't
12 thought about this and make sure that this is
13 understandable to them, because just on the
14 surface, it seems pretty complicated.

15 MS. TURBYVILLE: Thank you for
16 that comment, and not only will we try and
17 avoid jargon as much as possible, but the
18 document will be posted for public and member
19 comment. So I will encourage all of you. We
20 certainly do a lot of outreach to make sure
21 that folks are taking a look at it and
22 providing us comments, including such as it is

1 too -- filled too much with jargon. So that
2 is a very important point that we should keep
3 in mind.
4 DR. MARTINEZ: I worry sometimes
5 that we focus too much on the STEMIs and that
6 sort of stuff, and the system -- to me, the
7 capacity of the system really shows its
8 underbelly with the patients who don't fall
9 into that category.
10 If you look at CDC data, they will
11 show you only about 8 to 12 percent of the
12 patients shouldn't be in the ER. They
13 actually are so minor, they shouldn't be
14 there. In other words, this idea of what is
15 an emergency versus not is more than those
16 life threatening right in front of you.
17 The lack of access to time creates
18 the emergency. A good example I see all the
19 time is an asthma patient. An asthma patient
20 can be a little short of breath because they
21 don't have their medications and they have an
22 episode. The longer they wait, the worse they

1 get, and you can get to the life threatening
2 aspect of it.
3 So the capacity of the system
4 really reflects sensibility to deliver the
5 resources to that patient.
6 We have actually built a very
7 bizarre system now. We have two things. We
8 have a fast track, and we have the rest of the
9 ER, and if you have nothing wrong with you, we
10 have a place for you right away and, if you
11 are really sick, we have a place for you. if
12 you are a level 3, headache, abdominal pain or
13 shortness of breath, you wait in that waiting
14 room until you call CNN eventually, and they
15 show the videos, but that is what happens.
16 So I worry a little bit about us
17 making sure that we identify that they are
18 time sensitive and could become, as opposed
19 to, you know, they emergent and then we should
20 still be able to take care of the nonemergent,
21 because I don't consider them nonemergent,
22 those other patients. I consider them needing

1 acute care, and it is a real dilemma. How do
2 you frame that?
3 I just worry about that, because
4 if you look at screening out programs, the
5 most they can do is eight to 10 percent,
6 because that is what happens. So we are
7 talking a real small minority being
8 nonemergency.
9 CO-CHAIR ROSZAK: Kind of back to
10 our comments on that first paragraph on the
11 screen, it seems that a lot of that was
12 captured maybe on the slide before, and I
13 wonder if it is going to confuse the issue and
14 everything like that, do we even need that
15 paragraph? The one on the next slide that
16 talked about the disease conditions.
17 It is kind of repetitive. We have
18 said a lot of that in the definitions before.
19 Do we really even need that paragraph in
20 there? I'm not sure what the value added is
21 and if it is going to create the bait and
22 potentially confuse people, maybe we should

1 just eliminate it. I don't know. Ron votes
2 yes. Thoughts on that?
3 DR. MAIER: In the attempt to
4 capture everything, it is becoming a bit
5 rambling, and again it is very difficult, I
6 agree, to -- you know, what we just heard from
7 Rick, the challenges are there, and they need
8 to be addressed. The question is how much do
9 you put in the short definition.
10 CO-CHAIR ROSZAK: Right, and there
11 are, certainly, numerous other documents other
12 people can look at, and this isn't the be-all,
13 end-all of regionalization, and we try to, I
14 think, point that out by referencing a lot of
15 the great documents that have come before and,
16 I am sure, many that will come after.
17 So I just wanted, for the sake of
18 brevity -- and if people want to learn more on
19 regionalization, perhaps there's other venues
20 they can do that in, and this may not be
21 appropriate. I don't know. Thoughts on that?
22 John?

1 DR. FILDES: I have to agree with
2 you. In synthesizing documents like this, the
3 goal should be to deliver it at the sixth
4 grade literacy level, like USA Today does. So
5 if you can't actually explain this to a sixth
6 grader in the elevator going to the third
7 floor, then you missed it.
8 DR. CAIRNS: Obviously, these are
9 slides, and so the words aren't up there the
10 way they appear in print, and it is really
11 more of the concepts. But I hear what you are
12 saying, John. I mean, clearly, it has got to
13 be language that is understandable. Clearly,
14 it has got to minimize jargon, and clearly, it
15 has got to be consistent with the language
16 that we have discussed within the rest of the
17 framework.
18 DR. FILDES: And I would say that
19 it has to be consistent with the historical
20 path that this discipline of thought has
21 taken, too.
22 DR. CAIRNS: Well, it certainly

1 has to recognize it.

2 CO-CHAIR ROSZAK: All right. I

3 would like us to move on, if we could, just to

4 the domains, so we can get into the small

5 groups. Ron, you got one burning issue?

6 DR. MAIER: Let's go back to that

7 first little slide, number 2. We really are

8 talking about regionalized system. You can

9 make it systems, if you want. It is not

10 services.

11 DR. CAIRNS: Ron, did you like the

12 Systems of Care slides from yesterday?

13 DR. MAIER: The Systems of Care?

14 I don't know which one you are talking about.

15 DR. CAIRNS: Is it possible to

16 pull that one up?

17 DR. MAIER: All I am saying is, is

18 yesterday we had regionalized care, and then

19 we had systems of care.

20 DR. CAIRNS: Right.

21 DR. MAIER: And they seemed to be

22 saying exactly the same thing with different

1 words. But I think the concept that we are
2 going after is regionalized care systems, not
3 regionalized care services, which is what you
4 changed it to. That is all I am pointing out.
5 DR. CAIRNS: Thank you, sir. We
6 need to add the word systems. We will.
7 DR. MAIER: That is all I am
8 saying, is --
9 DR. CAIRNS: I got you. Remember,
10 the way that the project was entitled for the
11 RFP was Regionalized Emergency Medical Care
12 Services Systems, and we are going to add the
13 word systems. Then we will refer to it after
14 we get past that title aspect and initial line
15 to regionalized emergency care systems. Is
16 that fair enough?
17 DR. MAIER: Yes.
18 DR. CAIRNS: In the document, so
19 we meet both mandates.
20 DR. MAIER: Yes.
21 DR. CAIRNS: No, I heard you, Ron.
22 Thanks.

1 DR. MAIER: Because I realize that
2 you go on to define those services on both
3 sides as systems.
4 DR. FILDES: Right.
5 DR. CAIRNS: Hence, you can see
6 the reconciliation between the two charges.
7 CO-CHAIR ROSZAK: EMSS.
8 DR. CAIRNS: And in the rest of
9 the language, we will -- we use the word
10 systems, if that is acceptable to -- at least
11 in the next draft for review by our partners.
12 MS. TURBYVILLE: We will figure it
13 out. Thank you.
14 DR. CAIRNS: So the next charge
15 was to look at a review of the domains. You
16 will see, we added a new domain. Its current
17 proposed title is Capability, Capacity, and
18 Access. We kept the rest of the domains as we
19 discussed. Next slide.
20 So here is the new domain one:
21 Capability, Capacity, Access. There is a need
22 to understand the capability, workforce, and

1 resources of a regionalized emergency medical
2 care services within a region to provide
3 emergency care.
4 Again, forgive some of the
5 language here. We will get the document in
6 place to make it more close -- closer to
7 English, acceptable English, and I like the
8 sixth grade level guise.
9 Second: Capacity -- Excuse me.
10 go back to second paragraph: Capacity can
11 change rapidly. Therefore, the measurement of
12 a real time capacity of this system to provide
13 timely emergency care is important.
14 The third: Regions can vary
15 widely in the access to care, either for a
16 defined population or within the defined
17 geography.
18 So that would be kind of the
19 outline and, again, forgive the language --
20 the outline for this capability, capacity,
21 access. So the distinguishing features are:
22 There's got to be a capability, but that

1 doesn't mean that the capacity is necessarily
2 there. It is a dynamic and, clearly, how that
3 capacity is then accessible to the population
4 is another important component.
5 Domain 2 remained essentially the
6 same.
7 Domain 3: We kept the first one
8 the same for resource utilization,
9 recognizing, though, that a lot of the
10 resources for infrastructure, for capability,
11 capacity are going to now be captured in
12 Domain 1, we decided to refine the second
13 paragraph.
14 So: include structural and
15 process components at regionalized emergency
16 medical care that catalog facility, specialty
17 consultants and advanced service resources.
18 So this was the idea that we were
19 discussing yesterday on specialty. Frankly,
20 it came up again this morning about specialty
21 availability, capacity, and advanced care
22 availability.

1 Domain 4: Remained the same.
2 Domain 5: Remained the same.
3 Domain 6: We kept it the same,
4 Rick, recognizing that for the principles that
5 patient oriented processes now comes --
6 appears to be very important language to
7 include. Since this domain is entitled
8 Outcomes, we kept patient oriented outcomes,
9 but played around with the idea of adding
10 processes and outcomes to that first sentence,
11 or we could just keep it in the guiding
12 principle.
13 In the guiding principles, we
14 talked about how there should be patient
15 oriented outcomes as a key component. There
16 was a lot of discussion both yesterday and
17 today to capture patient oriented processes
18 and outcomes as a guiding principle. So that
19 is the language that we have been changing for
20 the guiding principle for the next draft.
21 This is a discussion now of the
22 domain of the outcomes, and the question is

1 whether or not to include patient oriented
2 processes and outcomes as a key component to
3 the domain.
4 Now one may argue, and I think
5 effectively, that patient oriented outcomes
6 are clearly going to be linked to processes,
7 and so these things are not -- It is going to
8 encompass processes. The question is whether
9 or not we want to emphasize it in the language
10 of the domain. Is that fair enough? Now we
11 are at outcomes. I just want everyone to --
12 at least the thought behind this -- Again,
13 this is just for your draft consideration, is
14 that we really wanted to be sure we focused in
15 on what is important
16 DR. MARTINEZ: Can I ask? Can you
17 just go back to where you have the processes.
18 Multiple times people have said, the way you
19 get things to happen is you have a goal, and
20 the goal is not people should live; the goal
21 is like we are going to get them to the
22 operating room in such and such a period of

1 time. That is our goal. Right? That is our
2 process goal, STEMI, our time with EMS, all
3 those things.
4 So I think it is going to be the
5 thing that we are going to measure to see
6 differences rather than outcomes. Outcomes
7 are sometimes really hard to see. So where is
8 it in here? Back?
9 DR. CAIRNS: I think the idea is
10 just linking those processes to outcomes. So
11 the component of this domain is to recognize
12 what are the important outcomes we are trying
13 to achieve.
14 DR. MARTINEZ: So this is the
15 output side.
16 DR. CAIRNS: Yes. Clearly
17 understanding that the actual measures may
18 involve processes linked to those outcomes,
19 and clearly recognizing that this whole system
20 is going to be geared toward outcomes. At
21 least, it is evaluation.
22 So the focus of the domain was

1 really on outcomes.

2 DR. RINNERT: Just a couple of

3 comments. I would remind us to put things

4 like capability and capacity in a glossary of

5 some sort, so people can understand the

6 differences between those things.

7 I guess the other thing I am not

8 seeing in our domains, and maybe I am just

9 still not awake yet this morning, but I don't

10 see an allusion to feedback process

11 improvement where the system is learning from

12 itself.

13 Every patient encounter or all of

14 the things we are devising are intended to,

15 hopefully, make our next patient encounter

16 better, more efficient, more effective, and I

17 don't know which domain that should fall in.

18 Maybe it is the outcomes one, but I think

19 there needs to be a strongly worded comment

20 somewhere in there that talks about we are

21 trying to do better each time, and the way we

22 do that is because we are informed about what

1 we did the last time or the last 20 times, or
2 maybe the last patient that didn't do so well,
3 maybe the last patient that should have come
4 to the tertiary center but didn't, those ones
5 that fall out, the sentinel events, and how we
6 are sort of learning from ourselves, I don't
7 know that that is captured quite yet.
8 DR. CAIRNS: I think it is an
9 important process, you know, kind of the
10 quality management construct. Again, there
11 are four different ways that we evaluate
12 measures, and included in that will be a
13 quality construct, as has been alluded to.
14 So I think quality will be an
15 important goal. I think the management piece
16 will be -- we could put in suggested processes
17 or put it into that framework.
18 you know, frankly, when you talk
19 about units of service in an episode of care,
20 you are into a quality management construct.
21 CO-CHAIR ROSZAK: I think it could
22 probably go in all of these, but I think it

1 definitely needs to be addressed throughout
2 this whole process. So I think that is a very
3 valid point. I want to make sure we get that
4 incorporated.
5 Let's wrap up with some comments,
6 and then we will get into the small groups. So
7 we've got Rich. We've got Gary. Art, I'm
8 sorry, I didn't see you over there.
9 DR. ZANE: Just a brief comment.
10 I think this is a pretty remarkable endeavor,
11 and the work that has been done has been
12 really good, good work out of, really, what is
13 a void.
14 One of the questions I have is
15 about the juxtaposition of access and capacity
16 and how you would define those with a unit of
17 measurement or not, because they are so
18 interrelated, and they can be perceived so
19 differently.
20 DR. CAIRNS: So I think one of the
21 concepts that was discussed yesterday -- It's
22 okay if I briefly respond? I think one of

1 the concepts that we are trying to synthesize
2 with that is that a capability of the system
3 can vary widely, but is an important kind of
4 key structure.
5 If you don't have a specialist or
6 if you don't have an EMS system or if you
7 don't have a destination hospital, that is
8 really important, and understanding the
9 parameters around those could be valuable.
10 A second piece is that the
11 capacity of that capability can rapidly
12 change. Demand would be one thing, for
13 example. Infrastructure compromise would be
14 another component that could influence that,
15 or a lack of availability of providers could
16 alter what the capacity of a capable system
17 is.
18 Then the third component of access
19 is how the patients actually are able to
20 access such a system. You may have a system
21 that is capable, that has the capacity, but if
22 patients can't intersect -- for example, 911

1 doesn't direct or they don't have access to
2 911 or they are a vulnerable population
3 without that first initial communication link
4 -- then, clearly, there would be a compromise
5 in access to a capable system with capacity.
6 That was the initial thoughts on
7 how we might put those things together,
8 because we heard so many -- we heard a lot of
9 discussion yesterday about the key components
10 to access. We talked about the challenge of
11 capacity, but we also heard and recognize the
12 wide variation in capability, say rural versus
13 urban system, rich versus poor, and we have
14 already talked about specialty distribution,
15 heterogeneity.
16 Those are the thoughts.
17 MR. WINGROVE: Could you go back
18 to domain 3? Is that one intended to only
19 include hospital components?
20 DR. CAIRNS: No.
21 MR. WINGROVE: That is what it
22 does, I think.

1 DR. CAIRNS: I think we could
2 certainly add -- You want to catalogue
3 services? But again, remember that the
4 language for the slides is different than the
5 language in the text, but we absorb your
6 comments that we need to be sure we have the
7 out-of-hospital components, although in the
8 new Domain 1, just to be sure, a lot of the
9 Phase 1 -- some of the Phase 1 things
10 regarding EMS are going to be captured in the
11 new Domain 1 under capability. Is that okay?
12 This is more about resource
13 matching.
14 DR. COOPER: Going back to our new
15 Domain 1 -- this may be, not wordsmithing, but
16 perhaps concept-smithing -- I think that your
17 last sort of response got at the notion that
18 the underlying principle here is access, and
19 that access is limited both by entry into the
20 system and by the ability of the system to
21 respond to that need.
22 So I would begin -- I think we

1 really want to begin with access rather than
2 begin with capability.
3 Second, as the terms, capability
4 and capacity have evolved over the last
5 several years, particularly in the disaster
6 medicine world, as all of us know, generally
7 speaking, capacity refers to the stuff and
8 space, and capability refers to staff -- you
9 know, the capability to actually operate that
10 stuff and space to the benefit of the patient.
11 So I think we need to be very
12 careful with those terms, because they may be
13 misconstrued, and I think we should probably
14 try to congruent to the extent that we can
15 with the way they are being used in the larger
16 world.
17 So I would talk about this set of
18 concepts in terms of access first and capacity
19 second, and then last, capability to actually
20 operate that system to the benefit of the
21 patient.
22 So in other words, this is -- If

1 you want to think of it this way, the Access,
2 Capacity, Capability is another way of
3 thinking about input, throughput and output in
4 different words. That is why I am glad Sally
5 suggested this earlier, that it is such an
6 overarching first domain rather than a last
7 domain.
8 DR. CAIRNS: Well put.
9 CO-CHAIR ROSZAK: All right. I am
10 going to turn it over to Sally, who is going
11 to talk about the group activities. We are
12 going to break into small groups of 10-15, and
13 we will do that for an hour. Then we will
14 reconvene in the big group.
15 So Eric and Sally will give us
16 some guidance and some direction on how we are
17 going to proceed.
18 MS. TURBYVILLE: Thanks, Andy. So
19 this is the opportunity to really kick around
20 these domains. We want you to go to your
21 groups, and I think we will do Group 1 here.
22 Group 2 can stay in the middle, and Group 3 at

1 that table over there.
2 There are some broad questions
3 that we are asking you to think about. It
4 includes the now six domains, making sure that
5 the group discusses whether or not the
6 proposed domains still make sense, based on
7 all the conversations that have taken place,
8 if there are any other missing domains.
9 Then also take a little bit of
10 time to think about the overlap among domains,
11 and I am sure there are some, but whether
12 there is an opportunity to collapse or combine
13 any of those. We are fine with six domains,
14 but spend a little time thinking about that.
15 Then depending on which group you
16 are in, we have a set of questions that Chuck
17 and Jeff helped us sketch out that we want you
18 to really take a critical view of.
19 So we are going to spend about --
20 how much time in the groups, Eric? -- one
21 hour. Then come back. Ask one of your from
22 your group to discuss what you guys decided

1 upon in that hour with the rest, and get the
2 committee's reaction.
3 A goal here is really for us to
4 walk away with a good final set of domains and
5 subdomains, and if you think about these
6 subdomains and the domains, they certainly
7 touch all parts of the episode of care that we
8 have been talking about.
9 The reason why they are s helpful
10 is it really informs the measure developers
11 and users and implementers. It provides them
12 a context to think about these measures. So
13 you will see some of them -- for example,
14 coordination of care, certainly, is probably
15 a bar underneath that episode. Others may
16 focus on certain parts of the episode more
17 than that one. But it does provide a lot of
18 context for measuring.
19 So the goal is, as Helen alluded
20 to yesterday, you can almost think of it as a
21 tree, and we are providing the branches. then
22 our hope is to populate these branches with

1 important assessments, measures of the quality
2 of care that is being provided, if that is
3 helpful. Yes?
4 DR. RINNERT: The domains we are
5 going to be working with this morning are the
6 ones we just evolved and are different from
7 what we were provided. So I want to make us
8 as efficient and sort of targeted as we can
9 be.
10 Are we going to be given the newly
11 defined domains with sort of their different
12 elements, so we can be succinct or are we
13 working off of what we were given yesterday,
14 because it is not as --- We have sort of added
15 some things, and I don't want it to get lost
16 because we are working off of information that
17 we had or the domains as we defined them
18 previously.
19 MS. TURBYVILLE: Thank you, Kathy.
20 I think, from what I heard from the changes in
21 the domains, there is general consensus on
22 that. Unfortunately, this was printed out

1 yesterday. So my request is exactly that,
2 Kathy, that you think about the domains as
3 they have been revised by the Steering
4 Committee in the past day and a half.
5 I think the questions should still
6 apply, but if you have other questions, they
7 are really just to help you get going. We are
8 not trying to restrict the conversation at
9 all. We just wanted to do some of the pre-
10 work for you and think about the questions,
11 but as you get together with your group, if
12 you think our questions are way off base, add
13 your own. That would be fine.
14 DR. PINES: Just a question. So
15 in these current groups -- so Group 1 is going
16 to do detection and identification -- Should
17 Group 1 do the capability, access and capacity
18 domain or should we -- each group do that
19 separately?
20 MS. TURBYVILLE: Our thought was -
21 - Great question, Jesse. Thank you -- that we
22 would have Chuck and Jeff work on that,

1 because we felt that, with a lack of
2 preparation and time for it, it may be
3 difficult. But to the extent that the
4 individual groups want to think about that, if
5 you finish early, you are more than welcome to
6 do that. But we are going to continue working
7 on that particular domain. We have even
8 gotten input this morning on how to better
9 contextualize it, and that will be something
10 you will see in the next draft.
11 So we will get your feedback not
12 necessarily on the subdomains in this meeting,
13 but we will certainly get your feedback
14 through email and conference calls.
15 DR. PINES: And just in terms of
16 what these -- how these groups should be run,
17 should we focus on the specific questions as
18 an outline for the group or should we focus on
19 some of the language or have a philosophical
20 discussion? I am just trying to figure out
21 what we are going to deliver back in an hour.
22 MR. COLCHAMIRO: I think it is

1 really a concrete set of recommendations,
2 looking at the specific questions and really
3 trying to provide any additional key points.
4 Really, it is more of a deep dive, giving each
5 group a chance to focus on each specific
6 domain, and again printed yesterday, so
7 recognizing that there have been some
8 revisions made already, but diving deep in,
9 coming up with some concrete recommendations
10 and supplementing some of the work done so
11 that we can look at it from maybe a different
12 perspective.
13 MS. TURBYVILLE: So, thank you,
14 Eric. So one of our biggest concerns is that
15 we are missing a domain, that we miss a
16 subdomain or that one of them is not quite
17 right.
18 We have talked about the domains
19 quite a bit as a group. So I think we have
20 come up with the six, but we want to walk away
21 today with what is pretty close to a final
22 set.

1 As far as wordsmithing, I think
2 that that can become very difficult in a group
3 dynamic, but concept-smithing, as Art put it,
4 is absolutely what we need. We need enough
5 input to walk away today with the final bunch
6 of domains and subdomains that will then
7 provide this platform for measure developers,
8 people who are building the data platform,
9 what can we do now and do we need to do in
10 order to do what we want in the future.
11 So it is both the here and now and
12 the forward thinking. If you think about a
13 domain -- for example, we might -- I do a lot
14 of work in resource use measurement. So there
15 could be a clinical domain of resource use
16 measurement as one way to think about it, and
17 within that there may be subdomains that are
18 targeting very specific areas of resource
19 utilization.
20 So we are still getting the big
21 picture of what is going on with cardiac heart
22 resources, but then within that there may be

1 clusters of AMI resource utilization versus
2 CHF resource utilization that provide more
3 concrete comparisons within, but clearly, we
4 are still interested in the domain as a whole
5 as well. So I don't know if that helps.
6 So it is an important task to get
7 you guys' input on these domains, and so we do
8 want some concrete recommendations back so
9 that Chuck and Jeff can walk away with their
10 charging orders to wrap up the next iteration
11 of the draft of this report.
12 DR. RINNERT: I hate to say it
13 again, but I think we need a copy of the most
14 recent determination on how the domains --
15 what the domains currently are, because we are
16 working off of something that is, while not
17 antiquated, it is not quite as well defined as
18 we had from this morning.
19 So I think, for our groups to be
20 most efficient and to give you the best input
21 we can, think we ought to have a copy of the
22 new domains, because I just made little

1 scratchy notes on here. I just want to make
2 sure we are giving you our best effort.
3 MS. TURBYVILLE: We can put the
4 slide deck on the flash drives and hand those
5 out. Great. Thanks.
6 So as I said, Group 1 will meet
7 over here at this table. Group 2 can go ahead
8 and get together at this larger table, and if
9 Group 3 could go over there, we can go ahead
10 and get started.
11 Eric and I will come around with
12 thumb drives, so if someone could take a
13 computer with them to each of the tables, that
14 would be great.
15 (Whereupon, the foregoing matter
16 went off the record at 12:12 a.m. and resumed
17 at 11:48 p.m.)
18 CO-CHAIR ROSZAK: All right.
19 Welcome back, everybody. Sounds like we had
20 some pretty good discussion in the small
21 groups. So looking forward to hearing
22 everything you guys talked about.

1 So just to kind of give you an
2 update of where we are at, it is 11:50 now.
3 We are going to talk about the different
4 groups. We have three groups that met. So we
5 are going to have a report out from each of
6 the groups, and then have a group discussion.
7 We are going to be serving lunch
8 around 12:15-ish. If it is okay with you, we
9 would like to make that a working lunch. So
10 we will do a working lunch and, hopefully,
11 finalize most of these issues, and then we
12 will move on to the rest of the agenda as it
13 was scheduled.
14 So for the first group, which
15 dealt with detection and identification and
16 also resource utilization, I believe someone
17 was going to do the report out from Group 1.
18 Who is the lucky person? All right. Nick, I
19 will give you the floor. Do we have slides
20 for these things or -- not really?
21 MS. TURBYVILLE: No.
22 CO-CHAIR ROSZAK: No, no, no, you

1 don't have to do slides. I wasn't sure.
2 Someone is going to capture the notes and
3 everything, I'm sure.
4 MR. COLCHAMIRO: Yes. I will be
5 capturing the notes here on the screen as you
6 are going along.
7 MR. NUDELL: Yes, I am the lucky
8 one here. To start off with, we changed the
9 name of the first one, Detection and
10 Identification. We changed it to Recognition
11 and diagnosis, and that is basically going to
12 capture the first contact with help, whether
13 that is a 911 call or an OnStar call or some
14 kind of a call for help, It is the first
15 contact. It would be a point of measure.
16 So the next one, Research
17 Utilization, was also one of ours, but we did
18 not change the name of that one.
19 So the general questions: We
20 generally agreed with the proposed domains,
21 although we had a suggestion for changing the
22 medical care coordination to include --

1 MS. TURBYVILLE: Nick, I think
2 this was where there was a discussion about
3 the disease-specific care coordination and
4 disease-specific resource utilization actually
5 becoming subdomains in Medical Care.
6 MR. NUDELL: There we go, yes.
7 MS. TURBYVILLE: So in thinking
8 about the domains of Care Coordination and
9 Resource Utilization, those were fine except
10 there was a desire of some of the group to
11 parse out disease-specific care coordination
12 and disease-specific resource utilization, and
13 put those as subdomains under Medical Care.
14 Did I get that right?
15 MR. NUDELL: Yes, rather than
16 being separate. Right.
17 CO-CHAIR ROSZAK: Why don't you go
18 ahead and give a readout of your discussion.
19 Then we will open it up to the group.
20 Probably makes the most sense, I suppose.
21 MR. NUDELL: So the next one, no
22 domains missing, and overlapping domains --

1 yes, we feel there are some that overlap and
2 that that is a good thing.
3 Now the things specific to our
4 domains: We were asked to talk about when
5 does the episode of care begin, and I kind of
6 mentioned it already, but basically we feel
7 the episode actually starts when the symptoms
8 begin, but the actual measurement point is not
9 going to be reliably determined until somebody
10 makes contact.
11 So in the typical 911 world, that
12 is when the phone rings at the 911 dispatch
13 center. There is a time stamp associated with
14 that. So that could be measured.
15 The system components that would
16 contribute to it: We feel very strongly that
17 there is a lot of opportunity for things to
18 happen prior to that 911 call or prior to the
19 episode actually beginning that may prevent an
20 episode. So we feel that there needs to be a
21 lot of attention paid to what happens before
22 somebody enters the recognition phase.

1 So that puts a lot of overlap
2 between the different phases, but we didn't
3 spend a lot of time trying to solve that part,
4 because that wasn't really part of our domain.
5 Next we were asked to talk about
6 the system level measures that would impact
7 this. So we left it pretty simple, that
8 system level measures have to do with
9 communications and being able to provide
10 information to many different people who are
11 trying to provide resources, whether that is
12 the dispatch center trying to make sure the
13 right kinds of resources go to a scene or the
14 transporting crews trying to make the
15 determination as to where they should take the
16 patient, in the hospital trying to make sure
17 the right resources within the hospital are
18 used, and then afterwards post-hospital care,
19 the right resources.
20 So there is a lot of different
21 interchanges of information that all surround
22 communication and being able to provide that.

1 So the system level measure is related to
2 being able to provide that information.
3 The last question was patient
4 centered episodes of care: Does that apply to
5 this domain? We felt yes.
6 MS. TURBYVILLE: And I think,
7 Nick, this is where earlier you were talking
8 about the overlap of Phase 1 and Phase 2 and
9 that these -- that for Detection and
10 Identification potentially resides in both.
11 Am I remembering correctly? Then Resource
12 Utilization spans the entire patient centric
13 episode and, in fact, the system as a whole?
14 MR. NUDELL: Yes, in capabilities
15 and capacities and access, access could follow
16 through throughout the whole episode, because
17 it could be to special pieces to various
18 things along the way. So that domain goes
19 across the phases. Am I missing something?
20 DR. RINNERT: I think that one of
21 the other thoughts that we had when you looked
22 at our episode of care, there is that big

1 population circle, and then there is the
2 interface between the population circle and
3 Phase 1, kind of that gray area which is where
4 identification traditionally would sit.
5 Certainly, there are population
6 measures that -- There's things that are
7 occurring in the population before an actual
8 event is identified. We need to ferret that
9 out a little better, and there is a huge gap
10 in there for being able to sort of -- the pre-
11 sentinel event.
12 The sentinel events are things
13 that are happening before there is actually an
14 emergency that someone recognizes and then
15 reports. That is sort of where that gray area
16 or overlap of Phase 1 and Phase 2 occurs. So
17 there are opportunities to think about how do
18 we have measures going on within our
19 population so we might better predict and
20 intervene before there is a need for emergency
21 services.
22 Then, certainly, in Phase 2 and

1 Phase 3, there are episode measures that will
2 inform what are the particular specific needs
3 of that individual patient? Will they need an
4 LTAC? Will they need other interventions
5 within the hospital phase or follow-on care?
6 Those are more episodic measures
7 related to a specific disease or a specific
8 management of a patient, which may be
9 different than the population measures, and
10 all of those will inform the system about what
11 sorts of capability and capacity is needed
12 versus what is already available, because
13 there may be a disconnect between what is
14 available and what is needed.
15 DR. MAIER: So I think, as an
16 extension of what you were just going through,
17 that we can educate the public or somehow
18 intervene to shorten the phase of the time
19 needed to make the recognition of the symptom,
20 for example.
21 Did you folks think that that
22 should become a part of the pre-hospital --

1 yes, thank you -- mission -- good word -- so
2 that the paramedics, EMTs, that pre-hospital
3 consortium. Is it part of that mission to
4 actually provide that education to reduce the
5 risk and shorten the recognition time?
6 DR. RINNERT: We didn't talk about
7 what were the workforce needs to be able to
8 address that. Certainly, a community
9 paramedic or home health nurse or community
10 patrolling by EMS providers or some sort of
11 advanced care person would be able to more or
12 less troll the population that they are
13 responsible for and maybe intervene earlier,
14 prevent the people from running out of
15 medication so they don't dip over and have
16 their CHF exacerbation and don't need to call
17 911.
18 That is all sort of in that
19 population Phase 1 before you hit that gray
20 area where Phase 1 and Phase 2 overlap,
21 because when you hit that gray area, someone
22 has made a recognition that something is not

1 right: I need to call 911.
2 That is a pretty reliable time
3 stamp. I mean, that call is a pretty reliable
4 and measurable kind of thing, but what we were
5 interested in was measuring what was going on
6 in the intervening days, weeks or months that
7 brought them to that point where something
8 finally happened.
9 So there are a lot of different
10 workers who can --
11 DR. MAIER: But just as we have
12 CPR training and so forth, could we expand
13 those concepts to make it an even, as you say,
14 entry into the recognition and entry into the
15 system earlier to prevent them it from being
16 a severe and acute episode or whatever, and
17 minimize the emergency needs of the disease?
18 DR. RINNERT: Sure. I mean, how
19 many times do I take care of the drunk driver
20 in the ED who fell asleep in their car and
21 didn't have an accident, and then further down
22 the road that patient actually runs headlong

1 into another car, and now I have a bunch of
2 people I am taking care of from a traumatic
3 injury standpoint, when if I had intervened
4 with the person who has the alcohol problem to
5 begin with, there is a lot of prevention that
6 -- just an example. So, yes, you are right.
7 MR. KIRKWOOD: I guess, to make
8 sure that the question you asked got
9 answered, was I hearing you ask that whether
10 interventions in that symptoms to reporting
11 time should be part of EMS's responsibility?
12 DR. MAIER: Yes, just as it is to
13 teach CPR and so forth. Yes.
14 MR. KIRKWOOD: Well, I guess my
15 answer would be EMS certainly plays a role in
16 that, but at least as the world exists today,
17 that is an optional component of what most EMS
18 agencies do, because it is not funded by
19 anyone, and the domain of people who should
20 intervene in that is much larger. It is a
21 public health issue.
22 CO-CHAIR ROSZAK: So it kind of

1 sounds like maybe one of the subdomains of
2 your Recognition and Diagnosis category may be
3 some form of public education or public
4 awareness or something like that. Is that
5 kind of safe to say? No?
6 MR. NUDELL: That is not really
7 the direction. At least the way I was
8 thinking about it while we were discussing it
9 was it could potentially in many cases be the
10 responsibility of the care providers who sent
11 the patient home to start off with, and maybe
12 there is follow-up from the staff, a CHF nurse
13 or just various other people who might prevent
14 it from happening.
15 CO-CHAIR ROSZAK: Mike?
16 DR. SAYRE: I think, not to get
17 too down in the weeds here, but I think the
18 issue is definitely one of trying to figure
19 out the strategies to shorten symptom onset to
20 actually taking action, and our group
21 certainly doesn't have the solution to that
22 problem. This is way bigger than just the

1 public education issue, and it is certainly
2 not clear to me who should be responsible for
3 that, but there needs to be a measure that
4 somehow -- and that has to be part of that
5 emergency, that system of care.
6 CO-CHAIR ROSZAK: I certainly
7 think, kind of comparing this to our fire side
8 colleagues -- I mean, everyone knows "stop,
9 drop and roll." Everyone knows smoke
10 detectors, all this stuff. There has been a
11 tremendous effort, public education campaign.
12 I don't know if this is the proper forum, but
13 there may be some stuff that we could draw
14 some similarities. Rick?
15 DR. MARTINEZ: Not to belabor, I
16 think the point has been made. Basically, the
17 issue here really, for us, I think, is to help
18 make sure there's measures, because now that
19 you know what you do and who does it and what
20 you have to do, all depends on what the issue
21 is and what is an effective countermeasure.
22 Could be anything.

1 CO-CHAIR ROSZAK: Skip, are you
2 still up or are you done?
3 MR. KIRKWOOD: I'm done.
4 CO-CHAIR ROSZAK: Okay. So kind
5 of getting back, I didn't really hear anybody
6 articulate. Was there subdomains in Domain 1
7 or Domain 2 that we had kind of identified?
8 I know you kind of got interrupted mid-stream.
9 So I didn't mean to throw you off your pattern
10 there.
11 DR. RINNERT: Do you mean Domain 2
12 and Domain 3?
13 CO-CHAIR ROSZAK: Yes, the now
14 renumbered Domain 2. So the Recognition and
15 Diagnosis domain and then the Resource
16 Utilization domain.
17 MS. TURBYVILLE: I don't think the
18 group really identified subdomains. There was
19 discussion about out of hospital and in
20 hospital, but because there needed to be
21 integration, the sense that I got from the
22 group was to not create these subdomains. Is

1 that right?

2 CO-CHAIR ROSZAK: I think, kind of

3 in the same line of thinking that you guys

4 were talking about, you know, recognition and

5 diagnosis, I'm not sure what all that bucket

6 would capture. Does that include things such

7 as does this region have access to 911? Is it

8 enhanced 911? Okay, so stuff like that would

9 be in that domain? Okay.

10 DR. RINNERT: Yes, the right

11 response to the right place to the right

12 services. That had to do with whether or not,

13 when you called 911, did they have the

14 capability for EMD. So did you have an

15 informed dispatcher who was engaging with the

16 caller, whether it was a bystander or patient,

17 in determining what level of what level of

18 response to send. Is it going to be a BOS

19 ambulance or ALS? Do I even have that in my

20 bag of things to send? Am I going to send the

21 lights and siren or not? All those sort of

22 determinations about the level of response and

1 making that determination -- those were all
2 sort of subdomains of -- I think it was
3 Recognition -- or Response?
4 CO-CHAIR ROSZAK: And then on the
5 resource domain, was there discussion about,
6 is this an appropriate domain to place things,
7 like wait times, boarding, diversion? Are
8 these the kind of resource issues that you
9 guys dove into or do you see that fitting
10 somewhere else, in maybe a different domain,
11 maybe on call coverage, stuff like that?
12 MR. NUDELL: Those were part of
13 all of those pieces of information that would
14 need to be communicated to somebody. So we
15 didn't go into the details of all of the
16 different kinds. We just assumed that we know
17 that there are lots of different kinds of
18 resource availability kinds of information
19 that need to be shared.
20 MS. TURBYVILLE: And I also heard
21 from the group that, for matching resources,
22 that there is a real lack of infrastructure

1 that needs to be brought out in the paper,
2 because of the -- yes, and communication being
3 one of those, to provide the ability to
4 appropriately allocate people to the right
5 resource. There is such a lack of
6 infrastructure there that would allow it to be
7 at a regionalized system, that that should be
8 a very big focus in the paper of what needs to
9 happen.
10 CO-CHAIR ROSZAK: Go ahead, Ron.
11 DR. MAIER: I want to support what
12 you are saying, but as an extension of that it
13 also gives the opportunity to standardize that
14 infrastructure also, which is another major
15 part of the lack of infrastructure, is that
16 everybody has their own wave lengths, their
17 own communication equipment. It would be a
18 very nice way to standardize as you provide
19 that infrastructure, so that it can be
20 interchangeable and intercommunicative among
21 the various regions and states and everything.
22 DR. COOPER: Two issues that I

1 didn't hear mentioned that perhaps could be
2 discussed at greater length are, first, the
3 penetrance of professional level emergency
4 medical dispatch systems.
5 A lot of people are not using
6 Clawson inter-APCO. You know, they are using
7 some home grown system which may not get
8 patients to the right place at the right time
9 quickly enough.
10 The other piece that I did not
11 hear mentioned that may deserve some
12 additional thought is the increasing
13 availability of electronic systems for
14 detection. Probably the prototype of that is
15 the Advanced Automatic Crash Notification
16 System.
17 I am sure that, as time goes by,
18 we are going to see other similar kinds of
19 systems through other types of disease
20 develop. I mean, just as sort of a really way
21 out thought, one could imagine that somebody
22 is internal, implanted defibrillator could

1 have a chip in it that says I am starting to
2 fail, you know, and let the pre-hospital
3 system know about that ahead of time. But
4 that kind of thing, I think, is something we
5 have to think about for the future.
6 CO-CHAIR ROSZAK: Anytime you
7 think about resource utilization, especially
8 around this context, I always think of
9 helicopter EMS, and I am surprised no one has
10 brought up any kind of helicopter EMS issues
11 yet. Skip, I'm kind of looking at you or Gary
12 or somebody in that corner to maybe talk about
13 it or at least address it, if appropriate.
14 MR. KIRKWOOD: Just a couple of
15 thoughts. One is that it has always
16 interested me that in other public response
17 disciplines like law enforcement and fire, we
18 have built multiple redundant systems. In law
19 enforcement, you have a city police agency, a
20 county sheriff, a state police and a national
21 response capability in a variety of Federal
22 law enforcement agencies.

1 Same thing in the fire service.
2 EMS is unique in that it is pretty much one
3 deep everywhere until we get to something
4 really, really bad, and when we bring things
5 like the National Disaster Medical System to
6 bear.
7 You know, it may be that, if
8 somebody takes a more systems approach and the
9 funding model becomes more rational, that you
10 could very well use a helicopter as a first
11 responder in an area that is 200 miles from
12 the nearest ambulance station and four hours
13 from the hospital, which would be far more
14 appropriate than what we do today, which is
15 fly people around over the top of large urban
16 cities, and crash occasionally.
17 MR. NUDELL: Thank you for raising
18 the EMD issue. I think we agree with you
19 completely with that, and we did mention the
20 electronic system detection concept. There
21 are actually medical devices that do that
22 also, like STEMI detectors and things like

1 that. So we are aware of that.
2 The issue becomes how do you have
3 a standardized measurement across lots of
4 systems, and the most reliable one at this
5 point in time, we feel, is the first phone
6 call or the first kind of notification into
7 the system, wherever that comes from. That
8 could come from one of those devices or
9 somebody actually making a call.
10 CO-CHAIR ROSZAK: Other comments
11 or thoughts about the group. I see Jesse,
12 Skip, Nick, Kathy and Mike were all on the
13 panel. Comments from the group? I think they
14 have captured the flavor of the conversations
15 well. Other thoughts about what may or may
16 not be included in this domain? Any
17 subdomains that you would like to see?
18 Anything that might be missing? No? Good
19 job.
20 All right. Maybe what we will do
21 is we will take a break here and get some food
22 between this first group and the second group.

1 Yes, let's grab the food, and we will take a
2 five to 10 minute break to grab some food.
3 Then we will come back, and we will do the
4 next two groups.
5 (Whereupon, the foregoing matter
6 went off the record at 12:12 p.m. and resumed
7 at 12:27 p.m.)
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1 A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

2 12:27 p.m.

3 CO-CHAIR ROSZAK: Let's try to

4 keep on task, and we will move the group, too.

5 I think, Eric, you had a couple of brief

6 announcements, just administrative-wise.

7 MR. COLCHAMIRO: Just as far as

8 getting to the airport, I know folks have

9 flights at different times. We checked with

10 Sheila and our staff here.

11 There is a shuttle that goes to

12 the airport every 15 minutes or so, and then

13 as well there are taxis, apparently, lined up

14 in front. So no need to reserve ahead. You

15 can just walk out there. There is a bellhop

16 who will flag one down, and it should be

17 within minutes.

18 CO-CHAIR ROSZAK: Super. So,

19 let's see, Group 2. They dealt with medical

20 care, which includes the out of hospital care,

21 the emergency department care, and inpatient

22 care. Let's see, I've got Dr. Carr, Dr.

1 Cooper. Who else was on here? Dr. Zane --
2 oh, everybody, a lot of actors on this one.
3 Who is the spokesperson for Group 2?
4 DR. CARR: I am going to take the
5 first swing, and then I am sure the team will
6 pitch in.
7 CO-CHAIR ROSZAK: Sounds good.
8 DR. CARR: So going in order with
9 the questions specific to domain 4 -- now 4:
10 When does the emergency episode of care begin?
11 This one is the only one we had
12 consensus on, and we greed that it should
13 begin with symptom onset begins, not at first
14 contact with medical care. There is plenty of
15 dialogue to be had on the others. This one,
16 do you want to stop, pause, for each one for
17 people to feed back?
18 CO-CHAIR ROSZAK: I think each
19 group was asked that question. So we can
20 probably just move on.
21 DR. CARR: Very good, very good.
22 So what determines whether a patient receives

1 medical care that met accepted standards?
2 So now things became muddy for us
3 promptly. So we started with the structure
4 that, I think, is pretty common in this, which
5 is to look at outcomes, processes and
6 structures.
7 We decided that for outcomes, you
8 know, hard outcomes are obviously the best,
9 and the ability to meet accepted benchmarks
10 for disease-specific, risk adjusted,
11 morbidity/mortality rates is important. We
12 think that that needs to happen at the
13 population level, and what that means in terms
14 of region or catchment is, obviously,
15 something that needs to probably be better
16 articulated, and a primary problem here is
17 that these outcome metrics don't exist, which
18 is why we very often rely upon the structure
19 process proxies.
20 So we think that a key component
21 here is to think about the data systems that
22 exist and to think about how we grow those

1 data systems and what those endpoints would be
2 if we grew those data systems.
3 So the second tier here is the
4 processes. As I think this crowd certainly
5 knows, the processes are all measured so that
6 you can proxy an outcome that you can't
7 measure or can't measure very well. So with
8 the idea that processes are -- the aim of the
9 process is to achieve an outcome, we thought
10 that the gold standard here -- this is a --
11 well, I guess it is a silver standard, because
12 it is not the outcome, but the standard for a
13 process is whether or not the patient received
14 evidence based interventions; as a second
15 tier, when no evidence based interventions
16 exist, we thought it was consensus based
17 interventions.
18 Then key within this process is
19 that systems level metrics be met that are not
20 condition specific, and we will sort of circle
21 back around on those again, but this is where
22 we start to think about not measuring

1 hospitals, not measuring providers, but
2 measuring systems.
3 With respect to the last one, the
4 structure piece, which is -- So structures
5 exist, obviously, to drive processes, all in
6 hopes of driving outcomes. This is, I think,
7 where we are stuck, because the processes that
8 we describe above are very dependent upon the
9 structure.
10 So we think that, just as in the
11 first part we thought that there needs to be
12 a strong push toward improving data collection
13 systems for outcomes, here we think that there
14 needs to be a strong push for driving some
15 sort of systems collection inventory for
16 resources and capabilities.
17 We couldn't get ourselves outside
18 of the pickle that you can't decide what
19 processes are the appropriate process for your
20 system to meet until you have any clue what
21 that system can or can't do.
22 So in the absence of understanding

1 whether or not a system has providers,
2 resources, fixed structures, you can't decide
3 what the metric to hold them to. An obvious
4 and, I think, straightforward example is, you
5 know, you could choose -- We have been using
6 STEMI a lot here, and holding a hospital
7 accountable to a time to cath lab metric in a
8 hospital that doesn't have a cath lab just
9 doesn't make sense. That is a nice clearcut
10 one. There are lots that are much less
11 clearcut, but without describing on the front
12 end what your hospital can and can't do, it is
13 hard to know then what standard they should be
14 held to.
15 I have a couple of other things to
16 say on this one, but I sort of, I think, maybe
17 want to pause, because I am sure my team, who
18 had plenty of opinions, might want to chime
19 in.
20 DR. FILDES: We all agreed pretty
21 much that the emergency episode begins when
22 the patient recognizes something is wrong, and

1 the education of the public and the primary
2 and secondary prevention measures deployed in
3 the general population affect how quickly
4 people access care -- gain access to care,
5 understand the gravity of their illnesses.
6 That is really, actually, part of
7 a system of care. The participants in the
8 system of care are responsible to help educate
9 and prevent the public. The problem with that
10 is that it has got an uncertain time stamp,
11 but in the hierarchy of that, you put about
12 things being optimal but perhaps unmeasurable.
13 We thought it was important to
14 advance that as an issue.
15 The next one, what determines
16 whether a patient receives medical care that
17 met an acceptable standard: Again, we backed
18 into that generically. Obviously, outcomes --
19 the crude ones are lived or died, functional
20 status at the end of hospitalization, things
21 that have published metrics, easy to define.
22 Then you back down to processes of

1 care, and did they get their antibiotic
2 timely, did they get their medication timely,
3 were they seen timely. All of those kinds of
4 things are the next level of surrogates.
5 Then finally, the structural ones:
6 Did the health care provider or did the
7 location where health care was provided -- was
8 it adequately staffed? Did it have the
9 equipment and things to do what they were
10 supposed to do? Obviously, if you take
11 somebody who is in labor to a sports medicine
12 clinic, you are not going to get a very good
13 outcome.
14 The next one is how is emergency
15 care integrated across settings? We actually
16 had a lot of discussion trying to define what
17 that means, but if you go to the public health
18 documents from HRSA and so forth, integration
19 of emergency care across the system includes
20 essential services such as mental health,
21 social service, child protective, public
22 safety, prevention, community partnerships,

1 community health, and those sorts of things.
2 Now I am not sure that is what you
3 were driving at. I would just pause for a
4 moment and see.
5 So in order to integrate all of
6 the kinds of things or even just to integrate
7 with other medical services. Let's say, you
8 integrate with out-of-hospital medical
9 providers or integrate with post-discharge
10 medical care and rehab or LTAC or integrate
11 with the data frame that you are collecting.
12 You actually need a system plan with
13 governance and authority, critical elements of
14 the infrastructure piece that you heard
15 earlier.
16 CO-CHAIR ROSZAK: Our group took a
17 similar approach. I was not the author of the
18 question. So I don't know who was, but --
19 DR. CARR: You know, I would push
20 back on that. I think we had a rich
21 conversation in our group about whether or not
22 this governance authority I was referring to

1 is a top down piece to build the system is
2 important or if you change the incentive,
3 which again is vaguely top down, and then
4 allow people to innovate to get to that
5 incentive, which is richer.
6 The example, the concrete
7 examples, that we talked about was the trauma
8 system is a relatively top down approach where
9 you are credentialed by whatever your
10 credentialing agency is as being a Level 1 or
11 a Level 2 or not, and Mission Lifeline sort of
12 went the other way and allowed facilities to
13 declare themselves to be a STEMI receiving
14 hospital or not, and then offered to help to
15 identify existing networks based on who was
16 referring to who, who was doing cath, who
17 wasn't doing cath, and then it allowed the
18 community to sort of build that up themselves.
19 At the end of the day now, if the
20 metric becomes time to transfer if you are a
21 non-cath lab hospital or time to cath lab if
22 you are a cath lab hospital, the system still

1 needs to all work together. I have more to
2 say about that, but I see Dr. Maier's hand is
3 up.
4 DR. FILDES: To finish up, though,
5 if you have a system with a lot of elements in
6 it, and you've got an element of out-of-
7 hospital medical personnel and in-hospital
8 medical personnel, and you've got disease-
9 specific programs and you've got an
10 information frame running, there has to be a
11 way for them to relate to one another in an
12 organized fashion, for them to integrate all
13 the things that they do.
14 In general, that is going to
15 require oversight by someone in authority,
16 leadership by the personnel in the system,
17 finances as an underpinning, and an
18 information framework in the background. That
19 is directly from HRSA's public health
20 document.
21 So the other things, I would just
22 say that required elements for a system of

1 care, really, to do this are legislative
2 authority, lead agency, and sufficient
3 financial underpinnings to carry it forward
4 and to be transparent in the public realm with
5 regard to the care provided. That is how I
6 would just see that.
7 Then the last thing I am just
8 going to talk about is what system level
9 measures are important in assessing the
10 quality of emergency medical care.
11 You can only measure things that
12 you can answer yes or no to, you can count, or
13 that have units of measurements associated
14 with them, such as time, weight, volume.
15 So in terms of doing that, we got
16 down deep in the weeds about some of the
17 disease specific things, but you can back up
18 from that and just talk about general response
19 time, seen times, transport times, time to
20 seen in ED, all the standard measures that are
21 already in place for many other things.
22 I don't think there are any new

1 and imaginative measures that haven't already
2 been tried out. That's all I have to say.
3 DR. MAIER: Well, I guess, sort of
4 just, I think, to reinforce what you have
5 heard, and that is whether you use the top
6 down or the bottom up approach, and I think
7 both have to be used.
8 If you are looking at structure
9 processes or outcomes, it seems what works is
10 having data and making it transparent. We use
11 the examples of the New York CABG outcome
12 studies. The reason why it improved
13 dramatically was they collected the data, and
14 they shared it with the public, and all of a
15 sudden cardiac surgery became much safer in
16 New York state, and it is pure data and
17 transparency.
18 I think you can use that to
19 utilize again the infrastructure, the
20 processes that you happen to pick or the
21 outcomes, but you have to collect the data,
22 and you have to share it, and it has to be

1 transparent and used.
2 I think the second part is, if you
3 take it that way, it makes it somewhat
4 simplistic, because with data you can make the
5 system move the direction you want, because
6 everybody sees it, and everybody wants to do
7 well.
8 The second is just to reinforce.
9 I think you have to have an oversight
10 structure which is global, and we have never
11 had that. So if you want various silos to
12 work together, you need to put them underneath
13 the same oversight structure and not under
14 different ones, because then we all play those
15 games at every level in our lives, in
16 business. Everything plays that system
17 against itself, and you get nowhere.
18 So I think, if we are really going
19 to move this system forward, this system needs
20 to be under one leader or one leadership model
21 and not left in a bunch of different silos
22 under different leadership so that it can be

1 continued without moving it forward as a
2 common system.
3 So I would just push those two
4 concepts as major goals that we need to do to
5 move the overall system forward.
6 DR. CARR: To add onto that, the
7 question -- On some level running through all
8 of this is how much of this can NQF can do?
9 How much is our mission versus how much is a
10 legislative mission?
11 So as I was trying to think
12 concretely about this, I offered something
13 that I had offered to the group. I offered it
14 internally, and we had a dialogue about it.
15 That is, how much should there be
16 shared risk, shared reimbursement, shared
17 accountability for unplanned critical illness?
18 The very specific examples that we were using
19 was, I think we talked about cardiac arrest
20 and we talked about whether or not EMS's
21 reimbursement should be tied to the ultimate
22 gold standard, patient outcomes, even though

1 they are very, very proximal, and even though
2 they may do perfectly on their process
3 measures, because there is no gold standard
4 for them. They are not the end of the chain
5 of survival. The end likely happens as an
6 inpatient or upon hospital discharge.
7 If we think the gold standard is
8 the patient's outcome, should we be advising
9 CMS, should we be advising the metrics makers
10 to be thoughtful about how they can make both
11 the hospital -- or the multiple hospitals in
12 the region and the EMS system all have skin in
13 the game. So they are all dependent -- their
14 dollar reimbursement is all dependent upon the
15 overall outcome, no matter what their part in
16 that game is.
17 You know, there is conversation
18 about this, and not everybody felt like that
19 was a fair thing to do. I look forward to the
20 group's conversation.
21 DR. COOPER: It isn't that all of
22 us didn't think that was a -- that there

1 needed to be shared accountability, but that
2 the system of penalties and rewards needed to
3 be aligned appropriately with the degree of
4 contribution to a particular outcome.
5 By definition, every component of
6 the system can really only be measured, in and
7 of itself, by its intermediate outcome, for
8 what it can do that particular phase of care;
9 whereas, the system as a whole can be measured
10 from start to finish. Very hard to hold any
11 individual component to that standard.
12 In America, we are in some ways
13 the victim of our history and our politics,
14 and we were so afraid, when the Republic was
15 founded, of tyranny that we divided --
16 separated and divided power so completely that
17 at times everyone is at odds with one another,
18 but to look at the disaster realm for a
19 minute, one of the things I like to say is who
20 is charge? Well, everybody is in charge of
21 what they are in charge of.
22 I think that is the kind of model

1 that we need to adapt here, to follow on both
2 Ron's and John's and Brendan's points. In
3 circumstances where this has been achieved,
4 where some measure of joint accountability has
5 been achieved, it has always been in the
6 context of a public/private partnership, that,
7 if you will, as we in New York like to refer
8 to them, the heads of the five families kind
9 of get together around a table with an
10 appropriate official from public health or
11 government, and they work together to come up
12 with a common public health oriented solution
13 that works to improve the system as a whole.
14 It is not unlike a unified command kind of
15 concept in terms of disaster management. But
16 in effect, that is what we are talking about,
17 isn't it?
18 When I am speaking to disaster
19 oriented people, I sometimes refer to our
20 emergency care system as an individual
21 casualty incident as opposed to a mass
22 casualty incident, but the systems of care

1 that are required are not unlike one another
2 in that the patient is like a baton in a relay
3 race, and it requires every runner to sort of
4 do his or her thing to make sure that the
5 baton doesn't get dropped. But there's got to
6 be a coach, and there's got to be somebody
7 overlooking the whole thing.
8 Again, it usually works best in
9 the context of a public/private partnership.
10 Why? Because the public has the authority,
11 and the private has the expertise. If we can
12 bring those together and find a metric that,
13 in effect, guarantees that warm and fuzzy
14 togetherness, we will be a long way down the
15 road, a long way farther down the road than we
16 are right now.
17 DR. SAYRE: I just wanted to agree
18 with Brendan and echo that I think that
19 implementing this shared accountability model
20 is critical for really making these
21 regionalized systems work, and that the genius
22 of this group, again, is that we are kind of

1 thinking that through, and we don't
2 necessarily have all the answers right now,
3 but I think this has really got to happen.
4 It may be that EMS, for example,
5 in cardiac arrest is held financially
6 accountable for what happens in the hospital,
7 to some extent, because they control what
8 hospital a patient goes to. If the hospital
9 isn't participating and engaged in the
10 appropriate way, then maybe they shouldn't be
11 taking patients there.
12 MR. KIRKWOOD: I guess, building
13 on what Dr. Carr said, I will go back to my
14 point about a system capability index, because
15 depending on the environment, EMS could do
16 everything just fine, and the hospital could
17 do everything just fine, and because the
18 patient was so unfortunate as to experience
19 their cardiac arrest 150 miles from the
20 hospital, the outcome could be suboptimal.
21 So if we are going to reward
22 either system components or systems as a whole

1 financially based on outcome measures, then we
2 have to put those within the realm of the
3 possible, which is, to come degree, varies
4 every place.
5 DR. CARR: That is a really
6 important point, and I apologize if we weren't
7 more explicit about it. So the CABG reporting
8 stuff is an important thing, too, because you
9 know in whatever report injury outcomes or any
10 outcomes in health services research
11 literature without appropriate mixing and
12 adjusting, and part of the case mix adjustment
13 in unplanned critical illness, I think, is
14 geography or is access to the right resources.
15 It just sort of echoes back to the
16 fact -- As part of Number 2, I was saying, you
17 almost need a separate set of processes for
18 each set of structures, and one of these
19 structures is whether there is a cath lab at
20 the hospital, whether you are 200 miles away
21 from the hospital, all of these pieces.
22 This is the piece where I think

1 where we are the most stuck, is if we don't
2 know -- It is hard, without having the lay of
3 the land, to know what processes people should
4 be held to. I don't know how we get around
5 that. Maybe it is to hit -- But here you
6 don't mean outcomes data. Here you mean some
7 basic logistics about or some descriptives
8 about what the hospitals can provide 24/7/365.
9 DR. FILDES: What I am hearing is
10 a discussion of why no one of these elements
11 on its own is enough, but why there needs to
12 be multiple elements joined together to really
13 oversee the medical care portion of this.
14 So it starts with the authority to
15 create a system plan and to monitor what
16 happens within the system, and it is laced
17 with financial incentive and disincentive and
18 perhaps even legal or regulatory incentive and
19 disincentive, and gap analysis that leads to
20 improvement through data framework.
21 We have heard all those things,
22 but I think that is how the puzzle pieces come

1 together.

2 DR. RINNERT: It occurs to me, and

3 I am surprised it hasn't come up in my mind

4 before this, but as Brendan was talking, it

5 occurred to me that we haven't really talked

6 about taking the population's needs and

7 marrying them to what the system provides.

8 So in other words, we need to look

9 at the populations that we serve, which may be

10 different in one area of the United States

11 versus another or in another country, and you

12 look at their disease burden, and you look at

13 their risks.

14 Some of those risks may be age or

15 comorbidities or the geographic location where

16 they are at or the activities that they do.

17 You take the population needs, and you could,

18 in fact, predict what resource -- what

19 injuries or diseases they might get, and then

20 you could then say, well, based on that, we

21 then have these -- this is the kind of health

22 care system that needs to surround this

1 particular population.

2 You would -- It is almost like the
3 old fashioned certificate of need thing. When
4 we were first looking at building hospitals in
5 this country, you had to submit a CON, and it
6 had to name who is this particular population
7 that you are serving, and why do you think you
8 need three hospitals or two hospitals,
9 whatever.

10 So it occurs to me that -- and
11 maybe this discussion has already gone on in
12 other forums that you all have engaged in, but
13 it just occurs to me, we haven't really
14 mentioned that, and thinking about what is the
15 population that is being serviced and their
16 disease burden and their risks. Then you
17 develop a system that will address what those
18 needs are.

19 So you would have population
20 measures that would help you understand what
21 the needs are, and then you would have system
22 measures based on what those needs are that

1 you need to meet. Then you would have disease
2 measures.
3 I don't know that we have
4 necessarily thought about systems development
5 in that way, but as Brendan was talking, that
6 was kind of what was occurring to me. Since
7 they are the ones that are talking about data
8 collection, and we don't have data to say how
9 many -- or what the performance needs to be,
10 it just tumbled to me that we haven't
11 necessarily included -- We can build a lot of
12 things, and we can measure a lot of things,
13 but are we really meeting the needs of a
14 community or the population we say we are
15 serving?
16 I don't know that we have that
17 information as part of informing the system.
18 DR. MAIER: But that is why we
19 have put such emphasis on the data component.
20 Just based on that -- you know, whether it is
21 the structure, the processes, the outcome,
22 whatever level of the process you want to look

1 at, we need more data, and we need good data
2 so that we can validate both need -- you know,
3 how many cath labs do you need, where?
4 That is how you build the system
5 with any logic. Then you monitor the system
6 with, again, data on the outcomes, and make
7 sure that your plan fits the needs of the
8 disease and the population.
9 As John just said, then you look
10 at the gaps based on the data, and you fill
11 the gaps in. But again, the one thing that it
12 really requires for it to work is somebody has
13 to be in charge. I sort of personally agree
14 with the public/private mix.
15 I think that those are the kind of
16 systems that worked well in the past, and I
17 think that is what we are evolving to. But we
18 have no consistent oversight. Whether CMS
19 wants to take it, or whomever -- I mean I am
20 not going to say which entity should do it,
21 but somebody needs to or we will never get
22 these disparate processes on the same page as

1 far as a system goes.

2 DR. COOPER: You know, part of the

3 reason that that kind of planning process has

4 come unstuck is because the health care costs

5 continue to rise, despite that kind of

6 planning process, and in and around the late

7 Eighties, mid- to late Eighties, early

8 Nineties, people said, well, this planning

9 process has failed; we really need to go to a

10 market solution whereby we individually

11 negotiate rates with hospitals, providers,

12 etcetera, etcetera, to drive the costs down

13 that way.

14 That having been said, I think

15 there is a perfect example of the fact what

16 you are saying, Kathy, should work and can

17 work does work, and that is, for all of its

18 faults, the VA system.

19 They function in terms of their

20 resource allocation just in exactly that way.

21 It is a mutual planning process that involves

22 the entire system, but the system has

1 governance, and every hospital has to make its
2 case for the number of providers and the
3 amount of resource that it needs, based upon
4 the population that it served.
5 With the advent of quality
6 measures within the VA, from which the NISQIP
7 system that the College of Surgeons uses, as
8 you all know, was born, that, I think, in many
9 ways is the proof of the pudding.
10 To me, while America being
11 America, we are never going to be in a
12 situation -- maybe not never, but certainly
13 for the foreseeable future, not in a situation
14 where we are going to see individual hospitals
15 collaborating, sharing data to improve best
16 outcomes and so on, I think a strong argument
17 can be made that emergency care is a public
18 good and that the public has an absolute right
19 to do that for emergency care, because there
20 is no caveat emptor involved.
21 You know, the public can't choose.
22 The public has got to go where the system

1 takes them or nearest trauma center, nearest
2 STEMI center, nearest stroke center, what have
3 you, when they are in the kind of mental state
4 where they can't make an informed decision.
5 So the public has to make that decision for
6 them.
7 Under those circumstances where
8 the public has to decide on behalf of the
9 individual citizen, because he or she cannot
10 do so on his or her own, I think a very strong
11 argument can be made that the public good
12 model applies, and that, therefore, it is
13 absolutely necessary to have some kind of
14 robust system of governance in place that
15 links the health care system with the public
16 health system with appropriate authority to do
17 planning and rational distribution of
18 resources.
19 CO-CHAIR ROSZAK: I definitely
20 agree, and I like -- Kathy, I like your
21 suggestion. I like your observation. I think
22 there is definitely a need for more public

1 health-like integration into these systems,
2 and based on local community need or regional
3 need, it makes all the sense in the world. It
4 is something that we, honestly, have lacked.
5 DR. RINNERT: And I think it is
6 interesting, if you look at bullet point four,
7 which I think was trying to capture what I was
8 saying, I think it is worded the opposite;
9 because what we are saying is we are taking --
10 What the system provides, we will try to make
11 sure it -- We need to define the needs of the
12 population, and then you build a system that
13 addresses them, not the other way around.
14 DR. MAIER: I like what I am
15 hearing, of course, but I think this is a
16 different meeting. Ours is about the
17 measures, and this is like how and what people
18 should do.
19 I will tell you, I think it will
20 change over time how you use the data, and
21 also it depends on how you are paid to do
22 things. I have been in a very capitated

1 environment, and you are stopping people from
2 going in the hospital, and instead of becoming
3 a colleague, I became a cost -- right? -- in
4 the ED.
5 So those things change. So I
6 think all you need to do is make sure that we
7 have a way to look at the population you
8 serve, what the problems are there, and then
9 what the system should do and how it does
10 everything else, I think we need to leave
11 open-ended for a change, an innovation, as
12 things go down the road.
13 CO-CHAIR ROSZAK: I realize we are
14 still up against the time clock here a little
15 bit. So I want to keep things moving along.
16 I did want to bring up, just
17 because I know it came up in a couple of
18 groups, especially about this medical care
19 domain. We have heard a little bit about the
20 time stamps and door-to-doctor and 911 to
21 arrival and all this kind of stuff.
22 I just wanted to know if you guys

1 had any discussion. I know a lot of areas in
2 the country are kind of moving away from
3 lights and sirens to every 911 call now,
4 triaging it along with emergency medical
5 dispatch.
6 I just would hate to see us set a
7 vision or a future out there where we are
8 still responding lights and sirens to every
9 little minor thing, a stubbed toe. It is a
10 great liability. It is a lot of risk. It
11 puts the public at risk as well as our
12 providers.
13 Was there any discussion of that
14 in the group about how we can kind of move
15 away from those time stamps?
16 DR. RINNERT: I think our group
17 addressed that, in a way, because we were sort
18 of thinking about how do you determine -- We
19 think it would be ideal if every call for help
20 was addressed and provided with the services
21 that were matched for what the need was.
22 That is done through a scripted

1 interview between the dispatcher and the
2 caller, whether it is a bystander or the
3 patient, to determine the level of need and
4 then responding in like fashion, whether that
5 is with BLS only. Maybe it is ALS or --- and
6 also then whether it is lights and siren or it
7 is a cold response.
8 So we sort of addressed that and
9 said that we thought that there was
10 opportunities, and there are examples out
11 there where that is what is done every day.
12 MR. LOYACONO: We certainly talked
13 about that issue. You know, about the only
14 response time standard, if you will, that is
15 out there is -- and you should get a name,
16 though -- first responder is here in four to
17 six minutes, and ALS there in about nine
18 minutes.
19 A lot of places adhere to that,
20 but it is based on cardiac arrest survival.
21 If the public has any knowledge of that, they
22 go, oh, you know, all the ambulances are

1 supposed to be there within nine minutes. But
2 most of what emergency ambulances run on in
3 this country, 80 percent-plus, I would say, is
4 really non-critical emergent situations.
5 To perpetuate that metric, many,
6 many systems still run lights and siren to
7 everything. It is in their policy; this is
8 what we do. There is plenty of evidence to
9 suggest that that is dangerous and not the
10 smartest thing in the world to do, and I think
11 we clearly don't want to do anything that
12 would perpetuate that.
13 Rather, I think it would be good
14 to start someone down the path of defining
15 what is an appropriate response, and when is
16 it appropriate to respond hot or cold and, as
17 Kathy is saying, many systems don't have the
18 tiers that APCO is based on, that Clawson is
19 based on.
20 In my own system, we have nothing
21 but paramedic-level ambulances. So it is kind
22 of pointless to have a BLS response, because

1 we don't have one to send. Likewise, you will
2 find places that don't have anything but a BLS
3 system as well.
4 I think it is a very important
5 point that needs to be pushed forward, if we
6 get the opportunity.
7 DR. CARR: But in the absence of -
8 - I appreciate that we don't have evidence,
9 and I am very glad, Andy, that you brought
10 this up. But in the absence of having
11 evidence, what we do is we come up with
12 consensus, and this room right now could tell
13 you that probably running lights and sound for
14 every non-urgent call is a bad idea.
15 So doesn't the metric then --
16 Doesn't this just get concretely boiled down
17 to the metric of you must have guidelines in
18 place that are consistent with the consensus
19 opinion, and I am sure that the National
20 Association of EMS Physicians and the other
21 organizations that I am too ignorant to know
22 about could provide that, if it was an

1 important thing to provide that, and that at
2 the county and the state level or the local
3 level, wherever the rulebook is made, if it
4 were a metric that you had on the books,
5 something that was consensus bound, that would
6 happen. Right? So that is metric one.
7 Can't metric two then be for the
8 EMS system, their compliance with their rules?
9 You could know when they run lights and sirens
10 above and beyond when they are supposed to,
11 and you can know when they don't, when they
12 are supposed to.
13 So a proportion of runs that are
14 consistent with policy -- seems to me, that
15 those are two very low hanging fruit -- well,
16 the first one, not so much; the second one, a
17 relatively low hanging fruit metric.
18 Those data -- I apologize that I
19 don't -- I am way outside of my domain. So I
20 don't know that data, and I am ready for the
21 beating, but I don't know if that data exists,
22 when you ran lights and sirens, when you

1 didn't, and I don't know if there is really
2 consensus about what proportion of the time
3 for each condition it should be.
4 MR. KIRKWOOD: There is probably
5 not evidence, but there is strong consensus,
6 and those are simple mandatory data elements
7 of the existing National EMS Information
8 System. So it is there. But I think we got
9 to make sure that we don't throw the baby out
10 with the wash water.
11 Using red lights does not
12 necessarily equate to trying to drive real
13 fast. Probably the most useful time you can
14 use red lights on an ambulance is when you are
15 going 12 miles an hour in an snowstorm, so
16 people see you and don't hit you, for example.
17 So I think we have to carefully
18 tailor, but whether you have -- My system is
19 like Tommy's. We have all paramedic
20 ambulances, but we still use the Clawson
21 classification system, because not only does
22 it separate ALS from BLS, but it separates

1 resuscitative, urgent and emergent things and
2 others pretty well.
3 So it is out there. It is a
4 matter of, again, providing incentives for
5 that to be used, which don't exist, and this
6 is another place where we got to reach outside
7 the health care; because I'll bet in half the
8 land mass of the United States that 911 and
9 emergency radio communication system is fully
10 controlled by someone who is not in any way,
11 shape or form part of the health care system.
12 That is the county Sheriff, who owns that and
13 who decides whether the dispatchers will
14 provide EMD or not.
15 So if there was a buck attached to
16 it someplace, he would at least have a
17 conversation.
18 MR. NUDELL: I just wanted to
19 address the data side of that question. When
20 it comes time to actually documenting these,
21 I think we need to be very explicit in what
22 exactly we think we mean when we say -- I am

1 not saying that we would use response type,
2 but using that as the old example, there are
3 five different starting time stamps for
4 response time and another five ending time
5 stamps.
6 So we need to be able to -- So
7 there is no standardization. So to just say
8 response time is not well defined. So when we
9 get to identifying things, we need to be very
10 specific, down to naming the field in the data
11 base that is used or the function that it
12 serves. Otherwise, there won't be any
13 standardization.
14 DR. RINNERT: I was just going to
15 support the fact that there needs to be a
16 standardized definition and a standardized way
17 so that, when you are measuring systems and
18 comparing them, maybe two neighboring systems,
19 that there is parity in the way things are
20 being compared, so that it is -- you know,
21 they are measuring it differently so they look
22 better than me.

1 I am just pointing up a generic
2 area over there, not any one individual.
3 MR. WINGROVE: We also need to be
4 mindful of the fact that some of these
5 decisions and discussions about EMS at the
6 local level get made in a political and
7 patient sensitive -- or a patient satisfaction
8 oriented environment.
9 Having once been forcibly dragged
10 out of an ambulance, because I responded
11 without my lights and siren to what the
12 bystanders perceived to be something real
13 emergent, like a -- I don't know, a gunshot
14 wound to the finger, evidence is fine. Safety
15 is fine, but again people who are not part of
16 our world get to have a vote in some of this,
17 and we have to be mindful of the impact of
18 that.
19 CO-CHAIR ROSZAK: All right. We
20 would like to move on to Group 3. I think
21 Tommy has the great fortune to report out to
22 the group. So I will turn it over to him.

1 MR. LOYACONO: Well, we had a
2 robust discussion, and we have a lot of
3 agreement with what I have already heard here
4 from the other two groups. What we didn't
5 have is consensus on who was going to report.
6 So I would like to call on the other members
7 of the group to fill in the gaps, since I am
8 working off of two sets of notes here.
9 With regard to the general
10 questions, we do believe that the six domains
11 that have been identified are just fine. We
12 don't think any are missing. We didn't really
13 find any overlap among those domains.
14 We did recommend making a change
15 to the name of the third domain. In the
16 second bullet, we think you should put a
17 period after the word care, so that it would
18 say "include structural and process components
19 of regionalized emergency medical care."
20 With regard to the specific
21 questions, we believe that the emergency
22 episode of care begins at the point in time

1 that anyone recognizes that a potential need
2 for emergency care exists. So not just the
3 patient, but the bystander who walks by and
4 sees the guy laying on the side of the road.
5 We recognize that it is hard to
6 capture the data on that, but oftentimes it is
7 available, especially with the advent of
8 cellphones where 911 is concerned. A lot of
9 times there is a bystander there, and in the
10 course of asking the questions you say, you
11 know, when did this first happen? So we
12 believe that the attempt ought to be made.
13 What system components are
14 necessary to coordinate care across the
15 settings? I guess I should slow down, in case
16 there are any -- Okay.
17 Rick provided us with some nice,
18 neat packages: data, communications, clinical
19 pathways and protocols, handoffs which we call
20 interfaces, and feedback mechanisms.
21 Some of the specifics that we
22 talked about was the availability of an

1 electronic health care record throughout the
2 continuum of care, so that there is data
3 sharing and data integration, and everybody
4 within the system is able to get outcome data,
5 understand where the patient went, what
6 happened to him, that sort of thing.
7 We talked a good bit as well about
8 shared governance and accountability. How
9 patients are being routed within a system: In
10 my own system, I am accountable to no one
11 outside of my organization for what I do, for
12 the most part, other than license my people.
13 It is just not appropriate.
14 There has to be some governing
15 entity that controls the whole system, if we
16 are going to get good data sharing, if we are
17 going to get people working on the same path,
18 and it is done at a local level in a lot of
19 places, but as we think about a regional
20 system, that we really have to think about a
21 governing authority of some sort.
22 What system level measures are

1 important to the system? The coordination of
2 appropriate care across the geographic and
3 populations. Packages: Again, cost,
4 morbidity, mortality, unscheduled returns,
5 unscheduled admits or readmits, rather,
6 absence or presence of the structured protocol
7 to guide the system -- goes back to
8 governance.
9 Are there patient centered,
10 efficient, time sensitive, and appropriate
11 cost efficient matrices that are based on
12 acuity? This got into the discussion that we
13 just had about lights and siren to everything.
14 But basically, level of acuity should have
15 something to do with what -- just how fast you
16 are moving, not only in the pre-hospital
17 setting but otherwise.
18 Then what outcomes are important
19 to EMS systems? Let me look on the other page
20 over here and make sure I didn't miss
21 anything. Final outcomes communicated to all
22 the units of service; transfers to the

1 emergency department and transfers to higher
2 levels of care, with and without admissions;
3 readmits, both to the ER, to the hospital,
4 within some period of time to be defined by
5 somebody besides us; unscheduled returns; time
6 to mortality in some number of days; being
7 able to capture patients that return somewhere
8 else.
9 I think it is a moving target, but
10 somebody comes into your system, goes out and
11 shows up somewhere else in a short period of
12 time. The system needs to be able to identify
13 that as a fallout.
14 I think that is what I have.
15 CO-CHAIR ROSZAK: Yes, I think the
16 buckets or the subdomains, the data, the
17 communications, the clinical pathways,
18 protocols, the handoff and transfers -- we had
19 a lot of great, kind of neat discussion of
20 what exactly those meant.
21 Even data like you just alluded to
22 -- do we know that this patient has been at

1 three of the four hospitals in the region over
2 the last week? You know, is there some kind
3 of a public health surveillance component here
4 that, hey, all of a sudden, X, Y and Z is
5 becoming a real problem in our region; maybe
6 there is something going on.
7 Communications: We talked a lot
8 about online and offline medical direction for
9 EMS providers, and where is that headed, and
10 where has it been or where is it heading? Is
11 there a single point of contact for the
12 ambulance? Could I call from the ambulance
13 and say here I come with this patient, and get
14 a response on what hospital is open, which one
15 can accommodate me, where I should go.
16 Clinical pathways and protocols:
17 A lot about do they exist? Do we have them?
18 Are they standardized throughout the region or
19 at least very similar? Is there some kind of
20 a standard EMS drug box, which amazes me that,
21 depending on what county I am in, I have to
22 lock up certain drugs and get all other drugs.

1 Then also in the handoff and the
2 transfer section, not only handing off between
3 pre-hospital to the emergency department, but
4 then that whole piece of inter-hospital
5 transport, and then also a piece that is
6 usually overlooked, the 911 call to the EMS,
7 the handoff.
8 So is there data there that is
9 being captured, and it goes back to a lot of
10 what you guys were saying in your group. Then
11 the unscheduled returns, including repeat use
12 of 911, repeat use of emergency medical
13 services, all that kind of stuff?
14 I think, Rick, anything else?
15 DR. MARTINEZ: I think you have
16 got most of it. I was going to say, the issue
17 of governance. I don't know if you mentioned
18 it, but we looked at it. We started looking
19 at communication and feedback to the system,
20 and realized that is a big problem in terms of
21 capability, is the loss of the patient, no
22 feedback.

1 So we talked about making it a
2 learning system and use that as an overarching
3 concept of being a learning system. So you
4 are constantly giving feedback between the
5 various players within the system, so that you
6 are always constantly growing.
7 Then the thing I was going to say,
8 we looked at it at interfaces and having a
9 structured way for interfaces to occur. That
10 is going into the hospital -- within the
11 hospital, and then within hospitals. Right?
12 So we see those as places where the -- and you
13 can frame these things in terms of patient
14 safety and efficiency, all these things.
15 The other thing I would throw up
16 is just one in terms of the last part. Tom,
17 I think we talked about cost or finances as
18 being there in terms of outcome measures. I
19 don't know if we had mentioned that or not.
20 Did you? Okay, that's fine.
21 Then the other thing I would throw
22 up is that 3 and 4 are really ones that you

1 could do a matrix that had at least input,
2 throughput, output, going back to Tom's point
3 or Art's point, and then compare that against
4 the IOM attributes. Right? So you could have
5 those things, and input, throughout, output in
6 transition. That may be a starting point for
7 a matrix.
8 CO-CHAIR ROSZAK: And I guess one
9 more thing as we think about care coordination
10 and particularly the governance part. Looking
11 at the training, the certifications in that
12 region, do people all have the same level?
13 DR. MARTINEZ: You know, we didn't
14 put workforce, and we should have.
15 CO-CHAIR ROSZAK: Right, and
16 looking at even equipment, how many times do
17 you go to a hospital, and I got to start this
18 kind of IV, because they carry this brand, and
19 this kind of IV because they carry that brand,
20 and some are needleless, and some aren't, and
21 all this kind of stuff. So that is a very
22 important part of the governance structure as

1 well.

2 Comments from the group?

3 MR. WILLIAMS: I just wanted a

4 quick clarification. I apologize. Could you

5 guys repeat your title change and where that

6 specifically was?

7 DR. MAIER: I think it was under

8 Interface. Was it five? What is the one with

9 the second --

10 MR. LOYACONO: It is Domain Number

11 3 of the new domains.

12 DR. MARTINEZ: It was the second

13 paragraph in one of the domains, and we just

14 thought you could stop it earlier. Keep

15 going. Right there. You see where it says

16 "includes structure and process components of

17 regionalized emergency care" -- period, is

18 what the suggestion was, because it may be

19 limiting.

20 DR. FILDES: I just want to bring

21 up a comment from our group that didn't carry

22 forward, but I thought this group might just

1 want to consider.

2 Under Medical Care, there's three

3 subdomains. So if one of the domains was out

4 of hospital care, logically the other domain

5 would be in-hospital care, and then under each

6 of those would be additional branch points or

7 subdomains. Just from a logical point of

8 view, that was a comment I made.

9 CO-CHAIR ROSZAK: Any other

10 comments about the domains or the work we have

11 done on the groups today? Pretty exhaustive

12 list.

13 All right. Well, at this point we

14 are going to switch over then, and be assured

15 we are going to put the timeline back up here

16 in a few minutes, and I want to make sure that

17 you all know that you will have additional

18 opportunity for input and comment on all this

19 stuff, and our great folks at UNC are going to

20 put this all into a nice document that we will

21 be able to see and look at and examine

22 together.

1 So I guess that kind of leads us
2 into our next section here, which is the
3 committee priorities for the second draft. So
4 I would kind of like to take just a little bit
5 of time and maybe just go around the table
6 just so we capture everybody's thoughts.
7 You know, as we have spoken about,
8 UNC is going to be redrafting this framework
9 based largely on everything that we have
10 talked about in the last two days. So I guess
11 I will start with Jesse. Is there any kind of
12 take-home message of the last two days'
13 discussion? What is of the utmost importance
14 that you want to make sure is reflected in the
15 document? I know it is hard to pick just one
16 or two things, but is there any direction or
17 any charge that you specifically would like to
18 give to the UNC folks?
19 DR. PINES: Sure. This is
20 something that I have said before, but just
21 make sure that we consider symptoms versus
22 diagnosis, and that that is factored in.

1 Also, just adding into especially a lot of the
2 definitions and wording wherever we say life
3 threatening to say potentially life
4 threatening, which I think would encompass a
5 large group of patients, and also that
6 patients with sudden symptoms would also
7 benefit from regionalization, even if they
8 don't have the true life threatening disease.
9 DR. MAIER: I think we are
10 woefully short on data, which is amazing at
11 this point in time, and I think we need to
12 provide the infrastructure and the mandate
13 that data be collected on whatever topic you
14 want to name, and use that data, make it
15 transparent, and utilize that data in an
16 overarching shared authority, shared
17 accountability ruling model so that we have
18 somebody who we know is in charge, give them
19 the mandate, share it with the caregivers to
20 develop a combination accountability to move
21 the process forward.
22 DR. FILDES: I would just say that

1 the work here is very good. The sets of care
2 and the domains and everything really mesh
3 well. I would say that the measures are out
4 there. They are commonly in use. They may
5 not have peer review substantiation, which I
6 know you seek, but response times are long.
7 That is usually bad, and if response times are
8 short, that is usually good. But I think some
9 of those things are never going to be tested
10 out.
11 So I would make a plea that we
12 consider using some of those things that we
13 know are valid but that may not have met
14 scrutiny at the level of peer review
15 publication.
16 I would also echo what others have
17 said, that we were asked to come here to talk
18 about measures, and what we have spent a lot
19 of time talking about is how to construct a
20 system that can measure itself.
21 DR. COOPER: I think that, as Ron
22 has said, that data is really at the core of

1 what we are all doing here; and as John has
2 said, without a congruent system to collect
3 that data, trying to develop quality measures
4 is extremely difficult.
5 I think that there are two things
6 that a document like this could do that could
7 really help us move in those directions. The
8 first is to make a strong case that emergency
9 care is a public good and, therefore, requires
10 a level of system oversight that the rest of
11 the health care system doesn't necessarily
12 enjoy.
13 Second, as the nation's health
14 care information systems continue to be
15 refined, that are hospital discharge data
16 abstracts that explicitly address emergency
17 conditions include at least an initial set of
18 vital signs so we can get some sense of the
19 physiologic derangement that results from the
20 time sensitivity of these conditions. I think
21 that would go a huge long way toward helping
22 develop a rudimentary set of measures that

1 could help us achieve our collective goals.
2 MR. KIRKWOOD: I agree with my
3 colleagues to my right, and I probably agree
4 with my colleagues to my left.
5 DR. MARTINEZ: I think there is a
6 lot of opportunity here. A lot of us around
7 this table -- it's funny. We have been
8 dealing with systems issues for years, and yet
9 health care still hasn't figured it out.
10 You know, Walmart can track a
11 pallet of sand around the world within 15
12 seconds. We lose them in the waiting room.
13 There is an issue there. But with the changes
14 going down the road, the financial survival of
15 a lot of these health care hospitals and stuff
16 will be dependent on our ability to work with
17 others, I think.
18 So this is a great opportunity
19 kind of created into a model. So my -- I am
20 very impressed with what I have heard, but I
21 do think we need to make sure that we just
22 don't have a document with a bunch of metrics,

1 but there is a model there that people can
2 see. But I think in the end they have to see
3 it as flexible and adaptive, because my
4 experience in California with -- They kept
5 changing the way they paid every like 22
6 months, is that you kept trying to change, and
7 the problem with something that is too
8 restrictive is you block innovation and
9 change, and so people don't adopt it.
10 So I think a lot of the measures
11 and things like that here will change over
12 time in how you address things, but I think we
13 just want to make sure we are flexible, and it
14 drives patient focused outcomes. That will be
15 the best of all worlds, in my view.
16 DR. ZANE: I just want to
17 reiterate what a great process this has been
18 and what a great product so far has come out
19 of this.
20 I think I would encourage as we
21 look at pre-hospital care and out of hospital
22 care that we require that practice is evidence

1 based, just as we are requiring it in the rest
2 of health care, which has been very late to
3 the table for pre-hospital care, and that as
4 we look to processes we don't overcomplicate
5 the issues and focus on blocking and tackling,
6 and look at simple evidence based metrics.
7 DR. CARR: A couple of people have
8 commented on data. I would like to add one
9 piece to that data element. Often when we
10 talk about data, we talk about outcomes data,
11 and I think that we -- in our group it became
12 very, very clear that it is very hard to come
13 up with processes of care that are not
14 dependent upon structure.
15 So I think we need some
16 fundamental structure data of what the system
17 looks like, so that we can appropriately come
18 up with tiered processes, because otherwise I
19 think we know what they will be. They will be
20 the lowest common denominator processes, and
21 we will all be unhappy with them. So that is
22 sort of my first point.

1 My second point is that I
2 strongly, strongly believe that, when you do
3 incentivized "coopitition," if we are not
4 running -- The patient being the baton and us
5 running in a relay is a great analogy, except
6 right now each of us gets a different color
7 medal at the end of the relay race, instead of
8 all of us either getting a gold or not.
9 So if we don't force ourselves to
10 compete and cooperate at the same time, I
11 think we miss an opportunity here.
12 DR. RINNERT: Of course, I agree
13 with Ron and a lot of the others around the
14 room that talk about the -- It flabbergasts me
15 that we are trying to build systems and
16 perform care without really knowing what the
17 numbers are. So the data dearth is just
18 astounding.
19 I would encourage us to get
20 information about the populations that we seek
21 to serve. That is why we are here. So I
22 think population measures, while hard to get,

1 are things we need to seek so that we build
2 systems that meet their needs.
3 Then along the lines of, as we
4 provide care, having each step, whether it is
5 Phase 1, Phase 2, Phase, 3, Phase 4, having
6 quality measures within each one of those and
7 have them feed back and inform not only the
8 populations that we serve, so they know what
9 they are getting, but it also informs the
10 system to go forward and improve.
11 MR. NUDELL: I also agree with
12 most of the comments that have been made. The
13 issue -- I am concerned about the issue of
14 data standards and that that is a process that
15 could take many years to work through.
16 There are a lot of activities that
17 are already going on data standards, and have
18 been going on. If we wait to start building
19 the measures until after those standards have
20 been put into place, that could take a long
21 time. So it would be nice to start with some
22 of the low hanging fruit, some things that we

1 can do without having that deep of a
2 requirement.
3 One that popped into my mind is
4 something that is fairly simple process-wise,
5 but most -- well, not most. Many EMS
6 providers can tell you which hospitals will
7 share patient information with them and which
8 ones won't. If you deliver a STEMI patient to
9 a hospital, you may or may not learn if it was
10 a patient that ended up going to the cath lab.
11 Did they triage him out with an EKG in the ER?
12 Did they refer him for follow-up?
13 Something as common and as simple
14 as that, there is no feedback loop, and that
15 is something that could be addressed without
16 technology.
17 Otherwise, the only other thing I
18 wanted to mention is it would be nice if we
19 could mention some of the current examples of
20 best practices that are being used in various
21 places. There are some people using
22 technology now to share information or to do

1 different things, and they probably would
2 appreciate getting that kind of attention,
3 because they have invested the time, energy
4 and money into doing that. So recognition for
5 them or using that as a learning point, what
6 can we learn from what they have done?
7 DR. KUSSKE: First of all, let me
8 say I have learned a great deal at this
9 meeting, and I appreciate being here.
10 I would like to say that one of
11 the things that I consider to be most
12 important is determining how we will know what
13 the outcomes are of this entire EMS system,
14 and what results we are actually getting.
15 That, I think, can be done with better data
16 collection at the hospital end, but that is
17 one thing I would like to see come out of
18 this.
19 I also think that the interface
20 that was talked about is very important, the
21 interface between all the providers at various
22 levels, because I have seen situations where

1 there has been things that have been dropped
2 because of the interface, and that has caused
3 some serious problems down the road, not only
4 between the EMS system and the hospital
5 emergency room, but between the emergency room
6 and the providers in the hospital, and even
7 between the providers in the hospital and the
8 eventual destination of the patient after they
9 leave the hospital.
10 So I think that all those things
11 are part of the system and need to be worked
12 on and, hopefully, discussed in this
13 publication.
14 The other thing I would like to
15 say which hasn't been talked about here very
16 much is that, when this is written, it should
17 be -- the attempt should be made to make it
18 consistent and congruent with the EMTALA laws,
19 because there's a lot of things that have been
20 discussing here, various issues, which are
21 covered by the regulations, by the state
22 guidelines, and by a number of things, which

1 if not dealt with, will possibly cause
2 problems down the road.
3 So I would hope that, at least as
4 this is being done, that there are some
5 considerations given to that statute, which is
6 an overriding feature in all this. Thank you.
7 MR. LOYACONO: I, too, really
8 enjoyed participating in this process. Three
9 comments.
10 You know, EMS has been called the
11 intersection of public safety and public
12 health, and I don't think I have ever heard it
13 put quite like Dr. Cooper did earlier, but
14 emergency services is just different, in a
15 way, and it is much more public interest than
16 other aspects of health care, because you
17 don't have a lot of choices when you are in a
18 crisis situation. I think this regulation
19 piece that we have talked about so much is
20 just extremely important.
21 We keep talking about pre-hospital
22 care and other emergency care. We need to

1 start thinking about pre-hospital care as the
2 pre-hospital component of emergency care.
3 When we stop thinking about it as a different
4 animal than the rest of health care, then we
5 will start seeing it studied and researched
6 and funded like other special interest areas
7 are. Well, special interests might not be the
8 right word.
9 Finally, I, too -- I think that
10 the solutions are not going to all look alike.
11 When regions develop very well defined
12 regionalized systems of care, they are going
13 to be very different because of many factors,
14 and we need to look at identifying centers of
15 excellence that we can put forward as good
16 examples that others can pick and choose
17 pieces of that will work in their systems, and
18 share their successes as well. Thank you.
19 DR. SAYRE: I agree.
20 CO-CHAIR ROSZAK: All right,
21 Chuck. What do you think?
22 DR. CAIRNS: First of all, great

1 session. Thank you all for participating.
2 Thank you for accepting an extraordinary
3 percentage of the draft framework, and for
4 your really useful comments and hard work
5 today.
6 I think those concepts that you
7 have discussed are important. I think the
8 challenge is trying to put them into a
9 framework that will be understood by those who
10 do performance measurement, and that is what
11 I look forward to working with our colleagues
12 from NQF to do.
13 I think your comments on the need
14 for leadership and structure and potential
15 policies should be something we will continue
16 a dialogue with our Federal partners on, and
17 thank you all again. It has really been an
18 honor and a pleasure to be here, and look
19 forward to your comments on the next draft.
20 CO-CHAIR ROSZAK: All right. At
21 this point, we open the public comment session
22 for those in the room or those who are joining

1 us by telephone. So anyone in the room who
2 would like to say a few words? Cynthia?
3 MS. HANSEN: So I will come out
4 from behind the post here. Thank you all very
5 much for the opportunity to have been able to
6 observe such impressive conversation and
7 expertise for the last day and a half.
8 As I mentioned yesterday, I am
9 Cynthia Hansen, and I work at ASPR. I had a
10 couple of comments that I wanted to put forth
11 for the committee's consideration.
12 Being with the Assistant Secretary
13 for preparedness and Response, the concept of
14 surge is quite critical and, while it is
15 essential that day to day operations be
16 successful, and I know that is the necessary
17 focus of this group's work, the idea of a
18 regionalized surge capacity in the event of a
19 catastrophic event is something I would put
20 forward for your consideration as an
21 additional element.
22 Secondly, with all the robust

1 conversations that happened, I would also like
2 to put forth to you as you describe the
3 domains to be sure and include psychiatric,
4 behavioral health examples, and to balance out
5 the Med-Surg focus. That is an easier
6 conversation sometimes to have, and also that
7 health care in this country is also delivered
8 through tribal health, either through 638
9 compacts or Indian Health Service.
10 I would hope that the intersection
11 and linkages with those emergency medical
12 services would also be considered as you look
13 at measurements.
14 I was really struck by -- I think
15 it was one of you guys who were talking about
16 the link with non-health care entities such as
17 sheriff's departments, and that those linkages
18 are in some ways part of the challenge of a
19 regionalized emergency care services, and I
20 know this is a tremendous challenge.
21 I would just bring forth these
22 particular issues for the group's

1 consideration. Thank you.
2 MR. MARGOLIS: To build on the
3 ASPR theme. My name is Greg Margolis, and I
4 work for the Office of the Assistant Secretary
5 for Preparedness and Response, and I would
6 like to also take an opportunity to thank each
7 and every one of you for participating.
8 As you probably know, this is a
9 project jointly sponsored by ASPR and ASPE,
10 the Assistant Secretary for Planning and
11 Evaluation, and based on where I work, I can
12 at least extend my appreciation on behalf of
13 Dr. Nicole Laurie, the ASPR, for your
14 participation.
15 It has been an interesting
16 experience. I have known many of you for a
17 long time, and this is a little bit of a new
18 role for me, being in the back of the -- in
19 the peanut gallery, if you will, as opposed
20 to around the table, but it has been a very
21 rewarding experience, and I applaud the
22 progress of the group.

1 Obviously, ASPR's interest in this
2 particular project really does focus on
3 emergency preparedness, and it does recognize
4 the fact that emergency preparedness is built
5 on an efficient and effective emergency care
6 system every day.
7 I am very encouraged at the amount
8 of conversation that has gone on over the last
9 two days that make sure that we measure and
10 report and come up with metrics to look at
11 variables such as emergency preparedness, ED
12 crowding, boarding and diversion, which Dr.
13 Laurie views as true preparedness issues.
14 The other thing is that I am
15 impressed as the group has gone around. I
16 would like to tell you how important a work
17 this will be.
18 Skip had a question early in the
19 dialogue of how is this going to be used. I
20 think it is going to be used in a lot of
21 different ways, but in particular, there has
22 been a fair amount of conversation about,

1 well, who is in charge, and how do we put
2 everybody -- make everybody responsible.
3 There is a variety of policy
4 levers that exist, and certainly
5 centralization and authority and
6 responsibility from the top down perspective
7 is one way that we can look at the emergency
8 care system, and may work in certain cases.
9 But doing that in a private sector health care
10 system is very challenging when the majority
11 of the system works in a very different way.
12 So in particular, I see this
13 project as really starting us down the path of
14 public reporting, and I would hope that you
15 all realize the incredible power in a private
16 sector world that public reporting can have,
17 and we are really starting to talk about for
18 the first time a way that we can, on a website
19 such as hospitalcompare or whatever, we can
20 actually allow elected officials, policy
21 makers and other people that have
22 responsibility for various sectors of the

1 population to be able to evaluate the quality
2 of their emergency care system, and to compare
3 it to other systems of similar challenges, and
4 hopefully then, to make resource allocations
5 and community decisions about what they are
6 willing to accept and how they want to start
7 to fix some of their challenges.
8 So there is incredible power in
9 the work that is being done here, and it
10 really has a tremendous opportunity to improve
11 emergency care in this country.
12 Then finally, it also has the
13 opportunity, maybe for the first time, for us
14 to start looking at aligning incentives to
15 start encouraging the type of behavior that we
16 want this private sector health care system to
17 deliver.
18 So again I thank you all for your
19 participation, and I will turn it over to my
20 colleague.
21 MR. MORRIS: Thank you. I just
22 want to thank you all for the opportunity

1 allowing me to sit here in the peanut gallery
2 and listen to great comments.
3 As I was taking notes, trying to
4 figure out what I would say, you have already
5 said it all. So I concur with a lot; a few
6 disagreements, but it is going to come out,
7 and I really look forward to looking at the
8 second draft and seeing, because right now
9 there are so many notes, I don't know what is
10 -- I'm versioned out.
11 In the Office of Health Affairs in
12 Homeland Security, we work with EMS, Public
13 Health, and disaster preparedness, kind of in
14 that triangle. So I am going to approach my
15 viewpoints from that standpoint. But if there
16 is anything we can do in our office to help or
17 any questions, please feel free to call us.
18 I will be working with Greg and
19 the other colleagues here to help make this
20 the best document we can.
21 CO-CHAIR ROSZAK: Operator, this
22 is Andy Roszak. Is there anyone on the phone

1 that would like to comment?

2 OPERATOR: If you would like to

3 comment over the phone, please press Star-One.

4 Sir, your line is open.

5 MR. KNIPPER: This is Ken Knipper.

6 CO-CHAIR ROSZAK: How are you

7 doing? Go ahead, Ken.

8 MR. KNIPPER: This is Ken Knipper,

9 National Volunteer Fire Council. I have

10 caught most of it the last two days, and find

11 it very, very interesting.

12 I would have to comment on the

13 fact that somebody made a comment -- A number

14 of times, a comment has been made to how

15 important the cooperation of the fire chiefs

16 and the EMS chiefs will be, and as the Chair

17 of the National Volunteer Fire Council, EMSR

18 Section, I would be interested in getting the

19 copies of the draft and being kept in the loop

20 on this.

21 MS. TURBYVILLE: Thank you, and

22 you can go to the NQF website which will have

1 the timeline of when the next draft will be
2 posted for public comment, and we certainly
3 would welcome your comments on that draft, and
4 we do take a look at them, and the Steering
5 Committee considers all of those.
6 So it is going to be posted for
7 public comment, as of now, sometime in July,
8 but the website will keep everyone updated, if
9 there are any changes. So that is the
10 National Quality Forum's website. You can
11 just put in NQF and Google it, and you will
12 find it pretty quickly.
13 MR. KNIPPER: Yes, I have already
14 been on it.
15 MS. TURBYVILLE: Oh, fantastic.
16 So, great.
17 MR. KNIPPER: Thank you.
18 CO-CHAIR ROSZAK: Thank you, Ken.
19 Operator, do we have anymore
20 comments?
21 OPERATOR: Not at this time.
22 CO-CHAIR ROSZAK: We will close

1 the public comment period, and we will move to
2 the last portion of the agenda for today,
3 which is the summary and next steps, and I
4 will turn the mic over to Sally here.
5 MS. TURBYVILLE: So I would like
6 to say I agree with all the -- Thanks to all
7 of you for taking time to participate. I
8 think your contribution has certainly enriched
9 the draft that we have. We have got a lot of
10 ideas about what to change now and how to
11 continue to drive the system to be improved.
12 I would like to thank my team at
13 NQF as well, Eric and Laura for keeping us on
14 target and preparing for this meeting.
15 That said, to go over some of the
16 next steps and, Eric, feel free to jump in if
17 I forget any, we will be synthesizing the
18 meeting notes. We will send those out for you
19 all to review. Those are eventually posted
20 for the public, as well as transcripts which
21 are being taken, and a recording, if you
22 wanted to listen to two days of conversation.

1 Again, we would certainly make that available
2 to you.
3 On the meeting summaries and
4 working with Chuck and Jeff at UNC and their
5 team -- and also thanks to you all very much
6 for all the hard work that you have done so
7 far -- we will revise the draft, and it is a
8 quick turnaround.
9 So we will be -- If we have
10 specific questions, we may contact a few of
11 you based on some of the concepts that have
12 been tossed around, so that we can more
13 quickly get that draft updated, but we will
14 then send the draft back out to all of you in
15 June.
16 We will convene on the telephone a
17 Steering Committee conference call after you
18 have had a chance to review the draft, get any
19 final inputs, make sure that you all agree
20 that it is ready to go out for public comment
21 for a posting, and then we provide 30 days for
22 that public and member comment.

1 After we get the comments back, we
2 put them into an Excel spreadsheet, and we
3 provide them to all of you so that you can
4 take a look, and make any suggestions if we
5 need to adjust the framework at all.
6 In the end, what we will be
7 looking for all of you is a recommendation
8 that this framework move forward as an
9 endorsed framework for this particular area,
10 which means it goes to the CSAC, which is an
11 oversight committee. They oversee all the
12 Steering Committee work. Then if they agree
13 with the recommendation, then it goes to the
14 Board of Directors.
15 So those are some of the details,
16 but stay tuned for meeting minutes -- summary,
17 not minutes. The minutes will be the
18 transcripts, but so making sure that we have
19 captured key concepts we will be working
20 directly with our UNC colleagues to keep this
21 framework moving along. Then stay tuned for
22 a draft in about three weeks, I'm thinking, of

1 actually -- yes, about three weeks.
2 Any questions about that?
3 DR. RINNERT: Are we doing the
4 conference call on the 21st?
5 MR. COLCHAMIRO: All of the dates
6 there are ballpark. So there is the little
7 thing next to August 10th. I forget that word
8 for it, but these are estimates of the dates.
9 It should be around that time.
10 I will send out, similar to what I
11 did for the orientation call, a little link,
12 and we will pick a day and a time around there
13 that works for the majority of the Committee
14 members.
15 DR. RINNERT: We are looking at
16 the August date.
17 MR. COLCHAMIRO: Right. The June
18 date is for the final -- is for the webinar,
19 and then we will have another one in August.
20 MS. TURBYVILLE: So that means two
21 more webinars from the Steering Committee, at
22 least, one to look at the second draft, and

1 then one to give us any guidance and reaction
2 to our solicited public and member comment.
3 This week you can expect an email
4 where we will nail these down or solicit your
5 input on availability, and we will get those
6 nailed down in stone really quickly.
7 CO-CHAIR ROSZAK: All right.
8 Well, I greatly appreciate again your
9 attendance, your effort, your contributions.
10 It was a great pleasure working with you, and
11 thank you again. I hope you all have safe
12 travels, and we will be talking soon.
13 I officially adjourn this meeting.
14 (Whereupon, the foregoing matter
15 went off the record at 1:49 p.m.)
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22

A

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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: 05-24-11

Place: Arlington, VA

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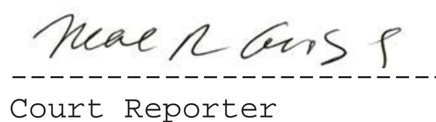

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