

Feedback in the Public Comment section

Document: Regionalized Emergency Medical Care Services

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Thank you for the opportunity to provide input on the National Quality Forum draft report titled “Establishing a measurement framework for regionalized emergency care systems using an episodes of care approach”. This report is part of the National Voluntary Consensus Standards for Emergency Care. The intent of this effort is to lay the groundwork for a more efficient, higher standard of care across the emergency healthcare system.

In response to the perception of an emergency system failure, the Institute of Medicine prepared a report, *Emergency Medical Services at the Crossroads*, which was delivered to Congress in 2006. The report states that: “*The challenges that exist in the system today can best be addressed by building a nationwide network of regionalized, coordinated and accountable emergency care systems.*”

With accelerating frequency, there has been a frustrating portrayal of the emergency system as wasteful, unresponsive, uncaring, and ineffective. A rational look at the system would provide a different conclusion.

There has been a failure to identify one of the greatest health care success stories in America; the success of efforts to reduce premature death. This multi-disciplinary approach has dramatically reduced premature death from sudden cardiac arrest and the reduced morbidity from trauma and burns. This development matches the impact of improved anesthesia, and vaccines and antibiotics for infection. Preventing premature death allows many more Americans to lead productive lives, and eventually to develop diseases of older age, like cardiac disease, cancer, diabetes, and neurologic deterioration. Those diseases have exacerbations that will predictably lead to the need for emergency care, and our economic system has not been adequately prepared to account for the cost of providing care to an aging population with more chronic illnesses.

The emergency system has been so effective in prevention, and in providing efficient care, that the emergency system has moved ahead more quickly than the rest of the healthcare system can support. We were certain to arrive at a time where the consequences of our prevention success met the realities of resource shortages. Instead of treating this as a health care system success, America has focused on the unprecedented expenses, and the failure of the health care delivery system to match the customer service successes of other industries.

The IOM report was disappointing regarding the look-forward challenges of emergency care. First, there are ongoing challenges to reduce premature death. These generally involve deaths from trauma, infection, and cardiovascular disease. The further challenges of emergency care revolve around the simple concept of providing the right care with the right personnel, at the right time, in the right place, with the right resources.

The Federal government long ago laid the foundation of the American emergency system by refusing to pay physicians for house calls. This led to the development of a sophisticated EMS system, busy and still growing emergency departments, “visiting nurses”, and “ask a nurse” programs. For those individuals and families who are able to pay for it (and not be shackled by the restrictions of an insurance company), a thriving “concierge medicine” industry brings the physician to the site of the patient. The future of the emergency system is a more systematic use of taking the emergency physician out of the hospital.

The program being developed by the National Quality Forum and other bodies needs to look more broadly at the needs of the American health system, and understand that the system needs extend beyond “emergency care”. The challenge is to develop a system for “unscheduled healthcare”. This concept fits the future needs of the American health care system, which continues to evolve into community-based and hospital-based medical care. The unscheduled care system must be accountable for effectively managing persons with unscheduled health needs, and efficiently moving patients between the two systems. The concept is characterized in Figure 1.

The term “Regionalized Emergency Medical Care Services” is probably not the appropriate one. The accountability for this system, and the dollars it would spend, extend beyond emergency care. The process of developing new delivery models should be done at a regional level, and would incorporate all the elements of unscheduled care. They could be

termed “regional accountable unscheduled care systems”. In the near term, considering the need to use popular terminology, the development could be under the term “regional accountable emergency systems”, or RAES.

Developing RAES would reverse the 40-year trend toward fragmented and decentralized emergency medical services. A proactive development of RAES would utilize and coordinate a region’s resources—prehospital, hospital and specialty—appropriately and efficiently. The system would be accountable to reduce premature death; provide efficient care of patients with unscheduled health needs; provide movement of patients needing specialized care; and preparing the community for major incidents. The medical care delivery elements of the system would be able to deliver needed care to a patient at a nursing home, or clear an accident victim on the street, or distribute patients to open emergency departments suited to care for them.

The regional emergency program should bring together EMS providers, Emergency Department leaders, 9-1-1 directors, physicians, payors and other stakeholders to effectively provide unscheduled medical care. Patients can be provided phone and computer access to a system that gives them care advice on unscheduled health needs, and links them to regional medical resources suitable for addressing their needs. Care needs to be delivered in homes, extended care facilities, and on the streets. Providers will include emergency physicians, nurses, paramedics, lab and xray techs, pacemaker technicians, and oxygen suppliers.

With the heritage of success in prevention and delivery, RAES are the next step in delivering efficient and effective care in an evolving health system. The design of these programs are the opportunity for emergency providers to work in a system that will deliver care at the right time, in the right place, with the right resources.

Establishing a Measurement Framework

There are established measures for performance of the emergency care system. These have been established over the last 19 years with the publication of the National Hospital Ambulatory Medical Care Survey (NHAMCS), from the Centers for Disease Control and Prevention. The NHAMCS report gives a statistical estimate of Emergency Department patients, treatment, and disposition, based on Federal demographic data and a statistical sampling of visits to American Emergency Departments.

The Emergency Department Benchmarking Alliance (EDBA) has conducted Performance Measures summits, and published three papers which establish reliable definitions for emergency department performance, and a method of utilizing cohorts to identify best practices.

The data guide developed by the EDBA reflects compiled measures of Emergency Department (ED) performance for American hospitals. The report presents the compiled data from the Emergency Department Benchmarking Alliance (EDBA) annual data survey. The results are presented in total, in cohorts for the various types of Emergency Departments, and in trended comparisons.

A sample of the important trending and planning elements available from the NHAMCS and the EDBA data survey is included as Figure 2. The NQF report needs to incorporate these already developed items, and the measures that are already published.

Still missing from the measurements are very important elements that reflect the reduction of premature death, and the positive impact of effective hospice and palliative medicine programs that are present in some communities. A critical element of future design is the reduction of community impact from premature death. Public health statistics do not currently reflect the impact of trauma, burn, and cardiovascular death prevention. The data element called “years of productive life lost” is useful for this calculation.

Cardiac Arrest Resuscitation Rates are a Poor Indicator of Emergency System Effectiveness

Resuscitation rates from cardiac arrest are low, should be low, and will not be increased significantly unless they count a small portion of the community’s cardiac arrest population. Congratulations to the Emergency System in America! This is a success story!

For many years, American Heart Association statistics indicated that about 675,000 Americans died of sudden cardiac arrest in the community. The CDC's NHAMCS data has confirmed a marked decrease in the number of cardiac arrests. The study was started in 1992 (1). As recently as the year 2000, the survey estimated that death from cardiac arrests accounted for about 379,000 visits to Emergency Medical Services and to Emergency Departments(2). The last year of the study that is published is 2007, and it found a decreased incidence of patients where CPR was utilized, to 166,000 patients(3).

Emergency Department staffs have also found low rates of successful resuscitation, unless the patient arrests in the presence of the ED staff. This was confirmed in a study that noted a major decline in the incidence of out-of-hospital incidence of ventricular fibrillation, and in all cases of cardiac arrest presumably due to heart disease in Seattle. These are one set of data points that reflect the national decline of out-of-hospital cardiac arrest and coronary heart disease mortality(4).

Observation and longitudinal statistical studies indicate that cardiac arrest is a condition that should be prevented, and low resuscitation rates are the norm. The results of attempted cardiac arrest resuscitation in sites other than airports and casinos is dismal, and in the study of that population, the rates of resuscitation will stay low no matter how much money is spent. The victims of cardiac arrest that are located in homes, nursing homes, businesses, and the streets are frequently not suffering from a disease process that is reversible. The result of these many processes is an apparent failure of cardiac resuscitation efforts by emergency personnel. This results in resources being misapplied to improve outcomes of cardiac arrest, rather than in primary prevention of premature death.

The element of community health that may be strongly correlated with cardiac arrest rates and the success of resuscitation is the presence and effectiveness of hospice and other "end of life" programs. If the regional health system has excellent programs in those areas, people in the community are better educated about end of life occurrences, and for patients with terminal illnesses, EMS is not activated as frequently. Therefore, cardiac arrest population rates are lower, and success rates of those patients who have premature, unplanned and unexpected cardiac arrests can be higher.

Emergency Department cardiac arrest outcome studies will be influenced by EMS removal policies. In some cities, cardiac arrest victims that remain in asystole have CPR terminated in the field, and are not transported to the hospital. If EMS removes all cardiac arrest patients, the resuscitation rates in the ED will be very low. If EMS pronounces most patients in the field after failed resuscitation, then the ED rates can be higher. The community rates of cardiac arrest should be reported as part of a hospital's resuscitation outcome data.

To understand the impact of cardiac arrest on a community, develop best practices, and apply community resources correctly, investigators should understand all aspects of cardiac arrest incidence. To investigate the rate of successful resuscitations that EMS and the Emergency Department participate in, EMS policy will have major impact

For good reasons, and reasons that support good health practices, it is not surprising that there are low rates of resuscitation from cardiac arrest. It is futile to assess an emergency system based on their inability to "raise the dead". Prevention of cardiac arrest is the key to a successful health system. The highest risk patients often have their own defibrillators already in their chest!! This is a success story for American health care, and we have missed the opportunity to celebrate!



Figure 1

Figure 2

The National Hospital Ambulatory Medical Care Survey: 2007 Emergency Department Summary, and the on-line 2008 Emergency Department Summary Tables

This is a review of the CDC statistical survey of Emergency Department operations. It is a wealth of information on Emergency Medicine in America, both the patients and the practice. It can be downloaded from www.cdc.gov/nchs. This latest report that is available in complete form, with analysis, is from the year of 2007. The National data now trails about three years behind the date of study. The CDC will no longer be publishing the annual National Health Statistics Reports. The data collection will be done, and reported only in table form. Therefore, it will be important to archive the 2007 report, for use as a reference when looking at the data tables in later years. The calendar year 2008 Emergency Department Summary Table was used for this analysis, and is available at: http://www.cdc.gov/nchs/data/ahcd/nhamcs_emergency/nhamcsed2008.pdf

The EDBA provides an analysis, so that ED leaders can compare local with national emergency care data.

It is critical that ED leaders understand the data and trends in this report. There is the opportunity to discuss this report with hospital and community leaders, and provide a summary of relevant information on local trends and the effects on your ED. The 2007 report and 2008 tables further highlight the use of various treatment and diagnostic modalities. This should be used to emphasize effective utilization of resources in every ED.

The 2007 report is 27 pages in length, and as always, the NHAMCS report is an easy read. The data tables for 2008 are 29 pages when printed. The report reviews census data, patient demographics, and ED operations, and the survey has 17 years of annual data. With this longevity, it has identified trends in the ED visits that are important for hospital and regulatory leaders to understand. The trends are (big surprise here): more ED visits, higher acuity, more medical presentations (as opposed to injury presentations), and older patients. In 2007, the author has focused part of the study on use of the ED by younger patients.

The 2007 data report is based on a sampling of 35,490 ED patient care reports from 357 Emergency Departments. National population census data was used to estimate utilization of ED services by patients. The 2008 data is based on the same methodology

Some data reporting for this year was done in the context of addressing issues in emergency care brought to light in the ACEP 2009 National Report Card; the U.S. Government Accounting Office report on ED Crowding; the Institute of Medicine 2006 ED Report on on-call issues and pediatric care; and the U.S. Department of Health and Human Service Healthy People 2010 Report.

Highlights of the NHAMCS reports for the years 2007 and 2008

- As expected, the nation's emergency departments continue to see volume increases over time. There were an estimated 116.8 million patients seen in 2007, and 123.8 million seen in 2008. The long-term volume trend is up about 2.3% per year. With the undercounting of EDs, it is undoubtedly an underestimate of the number of true ED visits in the country. Likely in 2011 we are seeing about 130 million patients in American EDs.
- The CDC numbers indicate that there were 236 visits to American EDs every minute in 2008.
- The rise in ED visits to increased use by adults, especially those 65 years old and over.
- The report raises significant issues about the emergency care needs of those living in nursing homes. Here were highlight points:
 - The ED visit rate was more than four times higher for those residing in a nursing home compared with those living in private residences. Nursing home residents account for more than 2.5 million ED visits, with the majority transported by EMS.
 - These ED visits result in admission to the hospital in 49% of the transported patients in 2007 and 2008. The average length of stay for a nursing home patient once admitted to the hospital is 7 days, longer than for other patient groups.
 - If one was to *conservatively* estimate that each of those ED visits cost the payors (largely Medicare, and some Medicaid) \$2000 for EMS and ED service, the cost of the emergency care of these patients was \$5 billion.
 - And most importantly, the cost of patients sent for evaluation in the ED and then returned to the nursing home was at least \$2.4 billion.
- The population studies indicate the utilization rate of the ED is 414 visits per 1000 population. The visit rate for Asian persons is 190 visits per 1000 population. The visit rate for Hispanic persons is 351 visits per 1000 population. The visit rate for white persons is 374 visits per 1000 population. The visit rate for black persons is 770 visits per 1000 population.
- About 35% of ED visits take place in traditional "business hours" of 8a to 5p on weekdays. The median time to see a physician was 35 minutes, and the median time spent in the ED was 154 minutes, which includes time with the physician as well as other clinical services. The survey is beginning to report time intervals in *medians*, which will match the recommendations made in the ED Performance Measures Summits.
- ED visits for injury, poisoning and the adverse effects of medical treatment accounted for over 34 percent of ED visits. This number continues to decrease.
- The highest injury rates are in those age 75 and older
- In 2008, patients arrived at the ED by ambulance in 15.8 percent of the visits, representing over 18 million ambulance transports. More than a third of patients who arrived at the ED by ambulance were 65 years of age and over. Almost 45% of patients over age 75 arrived by ambulance.
- Payor mix in 2008 was still stable in the economy that existed at that time. Private insurance accounts for about 42% of ED patients, then Medicaid and CHIP (24%), Medicare (18%), and no insurance (16%). Homeless persons account for about 1 of every 250 seen in American EDs.
- The 2007 and 2008 studies further delineated the use of diagnostic testing and treatment. About 18% of patients have an EKG performed, and about 13% have cardiac enzyme studies performed. These are increasing year over year. They counted about 15% of patients having at least one CT scan performed, and about half of those were CT scans of the head.
- There is a continuing decrease in deaths in and around the ED. There were a total of about 139,000 persons who were dead on arrival or died in the ED. CPR events continue to decrease in incidence, with about 119,000 undergoing this procedure in 2008. In the 2006 report, an estimated 166,000 patients had CPR performed. About 234,000 patients were intubated in total in the ED.
- Of the patients seen in the ED, the 2008 data indicate that 15.3% were admitted. This study indicates that the average patient admitted through the ED stays in the hospital 5.3 days.
- There were about 2.1 million patient transfers to a different hospital from the ED. The 2006 report had a feature section on Patient Transfers, and estimated that there are over 550,000 patient transfers for mental health or substance abuse patients. On average, that is 145 transfers per ED per year.

- There was an extensive analysis of the chief complaints and visit types for the 2007 patient population. This is based on a complaint list and diagnosis coding that is not the same as the ICD-9 coding that is used in billing. That list of complaints and diagnosis codes is much more useful in classifying the reasons for ED visits. As most ED workers would report:
 - For patients under the age of 15, the reason for visit was most commonly fever, cough, and vomiting. The most common diagnoses were URI and ear infections
 - For patients aged 15 to 64, the reason for visit was most commonly chest pain and abdominal pain. In females, the most common diagnoses were abdominal pain and ob/gyn problems. In males, the most common diagnoses were wounds.
 - For patients over the age of 65, the reason for visit was most commonly chest pain, shortness of breath, and abdominal pain. The most common diagnoses were chest pain and non-ischemic heart disease.

ED Planning Aspects of the CDC numbers

The ED population is aging, in line with the demographics of the country. ED visits have increased over 11 years from 369 visits per 1000 population to 414 per thousand. Those persons over age 75 had 679 visits per 1000 population. What does that mean for ED planning? ED leaders need to prepare for larger numbers of patients, and develop processes that are more friendly to the older population.

The highest visit rates per population were for those persons under age 1. There were about 855 visits per 1000 population for those 12 months of age and younger. So by the numbers, essentially all newborns are seen in an ED their first year of life. But this number is actually down from 10 years ago, when visit rates were about 1100 ED visits per 1000 population.

The survey numbers confirm the higher acuity trend. More high acuity visits, more older patients, more diagnostics, and more admissions. Importantly, the CDC report trends the diagnoses. Injuries continue to shrink, and now represent 34% of visits. The biggest increase in injuries is occurring in one group: the elderly.

There is ongoing increase in use of diagnostic tools in the ED, especially EKGs, CT, MRI, and other special imaging procedure, like ultrasound. The trend in increasing use of 12 lead EKGs will continue. The use of CT scanning is likely to peak in the CDC statistics in the year 2009, and the use of MRI imaging is going to increase.

Combining the results of the NHAMCS Report and the EDDBA Data Survey

The EDDBA annual data survey is now being completed for the year 2010. This report is noting different trends in some areas than the CDC study, and is able to be completed 3 years ahead of the NHAMCS report. The EDDBA report shows ED visit rate increases in the year 2009, and then a volume decrease for 2010. The EDDBA data finds continuing increases in patient acuity, EMS arrivals, admissions, use of EKGs, and percentage of hospital admissions that are processed through the ED. ED lengths of stay peaked in 2008, and the number of patients that walk away from the ED before treatment is complete, has decreased.

This combined data table should be used to complete the report for an Emergency Department, and compare them to the numbers from the NHAMCS and EDDBA surveys. This allows ED leaders to provide an accurate report on ED operations to your hospital leadership and community.

Demographics	National Survey	Your Emergency Dept
Volume 1992-2007	Annual increase about 2.3%	
Payor mix	Payor Mix Published	
Arrival time to ED	Table Published	
EMS Arrival	16%	
EMS Patients Admitted	43%	
Pediatrics (under age 18)	21%	
Workup		
Respiratory Treatments	10 treatment per 100 patients	
Medication Utilized	About 180 doses per 100 patients	

EKGs Utilized	24 EKGs per 100 patients	
Imaging Utilized	44 Xrays per 100 patients	
CT and MR Utilized	22 Studies per 100 patients	
Patient Disposition		
Admission	18%	
Transfer	2%	
% of Hospital Admissions Coming From the ED	66%	
Leaving before Treatment Complete	1.9%	
Median Length of Stay	186 minutes	
Median Length of Stay Admitted Patients	279 minutes	

The admission percentage from the ED keeps creeping higher, despite more stringent criteria for admission. There are higher admission rates at the larger hospitals seeing adult patients. There is a continuing growth in the percentage of overall hospital admissions presenting thru the ED. The average number is 66%. This clearly demonstrates that the ED is the “Front Door to the Hospital”.

Summary Talking Points

- There is a long term trend that American EDs are seeing about 2.3% more patients per year.
- The average American ED is seeing more than 33,000 patients per year.
- More patients arrive with medical illnesses, rather than injuries.
- More patients are elderly, and arrive by EMS.
- The largest group of patients being seen in the ED have private insurance.
- The highest utilization of Emergency Services occur among nursing home residents. The next highest utilization is by infants under age 1

References

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**NQF's Report on *Establishing a Measurement Framework for Regionalized Emergency Care Systems Using an Episodes of Care Approach*
Comments Submitted by The Joint Commission on August 23, 2011**

Does the framework adequately provide for measurement of both individual patient care and the measurement of “regionalized emergency care systems”?

The Joint Commission appreciates the opportunity to comment on NQF's report on *Establishing a Measurement Framework for Regionalized Emergency Care Systems Using an Episodes of Care Approach*. Emergency care is a critical component in our nation's health care delivery system. Thus, developing a usable measurement framework to assess how well this critical component functions is of utmost importance.

Although the domains and subdomains of the framework address important aspects to consider, without measures it is difficult to gage their usefulness. Through its experience as a measure developer, The Joint Commission has identified that a framework that appears useful in concept does not always translate well in the implementation phase. Therefore, without more detail regarding the availability of measures for each domain/subdomain or information on the data that is available to “build” measures, it is difficult to determine the adequacy of the framework for measuring individual patient care and/or regionalized emergency care systems.

In selecting measures for this extremely important component of our health care system, The Joint Commission urges NQF to adopt its accountability framework for classifying measures. This framework uses the following criteria:

- **Research:** Strong scientific evidence exists demonstrating that compliance with a given process of care improves health outcomes (either directly or by reducing risk of adverse outcomes).
- **Proximity:** The process is closely connected to the outcome it impacts; there are relatively few clinical processes that occur after the one that is measured and before the improved outcome occurs.
- **Accuracy:** The measure accurately assesses the most critical process components. That is, if the measure construct does not support data capture and assessment of the most essential process components, it is a poor measure of quality, likely to be subject to workarounds that induce unproductive work instead of work that directly improves quality of care.
- **Adverse Effects:** The measure construct is designed to minimize or eliminate unintended adverse effects.

The Joint Commission also urges NQF to consider adding a section that has a special focus of emergency services for individuals that require behavioral health care. In part, due to local shortages of community mental health programs and a lack of inpatient beds and specialized mental health staff, individuals with behavioral health care needs are often cared for in a very fragmented and dysfunctional manner. These individuals are spending days, not hours in our emergency departments. It is not unusual to visit any emergency department across the nation today, at any given hour, and find that multiple mental health patients' are being held in the emergency department with no resolution or assistance in finding placement or treatment in another venue. Measures that set a baseline for existing systems and inform improvements should be a goal of this initiative.

In addition, the report needs to discuss the challenges rural critical access hospitals and rural emergency medical services (EMS) face. These areas generally have a lack of resources, staff and expertise, which must be considered in a framework that is developed to measure regionalized emergency care systems.

Does the “Episode of Care” model, as a patient-centered construct for evaluating care, also adequately allow for system-level evaluation? If not, how might the framework be modified to ensure adequate measurement of regionalized emergency care systems?

While The Joint Commission supports the episodes of care model, it is important to note that our nation’s emergency departments are overburdened with patients who do not have a primary care physician and who utilize the emergency department for routine health care. Emergency departments continue to be plagued and overburdened an indigent population that lacks resources to pay for needed, individuals with behavioral health care issues that do not have other sources of care, and people seeking care for minor medical problems and/or routine medical care. A construct for conducting a system-level evaluation must have measures that help to assess these factors to truly capture the role emergency departments’ currently play in our health care delivery system.

It is also important to note that regionalized emergency care systems frequently cross state lines, or include several states bundled together. Yet, there can be a great disparity between the rules and regulations that govern these systems in each state. These disparities include different licensing requirements, transportation and treatment systems, as well as management regarding their emergency preparedness response to major disasters.

Additionally, the model for an episode of care evaluation does not take into account rural hospitals that lack sophisticated technologies and have extended transport times.

Post other comments pertaining to this draft report here.

Below are specific comments for NQF’s consideration. Again, thanks for providing The Joint Commission an opportunity to review the report and provide these comments.

General Comments

A region is not clearly defined in the report. It should be clearly defined in the document and the definition should be included in the glossary.

Patients in states that border each other are often moved from one state to another for level 1 trauma care, severe burns, neurology care, etc. These cross border situations must be taken into consideration, when establishing the definition of a region.

Guiding Principles (line 126). Measuring and monitoring alone cannot ‘ensure’ that appropriate resources and workforce are available; for example, incentives driving physician training and practice decisions, licensing and scope of practice regulations affecting nurses, etc. also need to be considered at a regional level.

Domain 1: Capability, Capacity, Access

NQF should consider explaining the role of Veterans’ Affairs (VA) hospitals and emergency services to veterans in the report. This role should include how VA hospitals can participate in building surge capacity within their community responders and receivers.

Public health initiatives. The Joint Commission is a strong supporter of public health announcements to prepare the public for pandemics and seasonal epidemics. It should be recognized, however, that there are significant barriers for many people who hear the messages, but fail to act. These barriers include patients’ that lack a regular provider of primary care and/or enough money to seek care in a retail-based health clinic or urgent care clinic. Therefore, when these individuals get the seasonal influenza, it is highly likely that they will seek care in an emergency department. All too frequently our nation’s indigent population and individuals that have mental health issues have no recourse or resources other than to seek care in an emergency department.

Preparedness, monitoring, and data sharing. The Department of Health and Human Services requires the development of Health Care Coalitions to extend surge capacity during disasters, so measures related to hospital partnerships with ambulatory care, home health agencies, long term care facilities and other types of providers need to be considered.

The Joint Commission questions, if, in this initiative, NQF assumes that an episode of care during a disaster has the same components and hand-offs as an episode of care during ‘normal’ operations? (Please see lines 566-567.)

Transportation considerations need to be added to this section because they are a tremendous challenge during a disaster. For example, during Hurricane Katrina, patients were trapped in flooding hospitals because of the lack of transportation. Patients were moved on boats, trucks, and commandeered buses. Medical supplies and the movement of critical patient’s away from facilities had to be planned at the last moment with aero medical support from across the nation.

Domain 2: Recognition and Diagnosis

Community awareness. Measurement of a community’s awareness can be further supported by providing the locations and education of any equipment the community participants may utilize. (Please see lines 595-602.)

In the discussion concerning Episodes of Care on lines 632-636, we ask NQF to consider the following questions: When does an episode of care end? At discharge from hospital? When patient completes community referral after discharge from emergency department?

Domain 3: Resource Matching and Utilization

The Joint Commission urges NQF to consider moving this section up in the report because it provides a clearer picture of what is trying to be accomplished in the framework.

Domain 4: Medical Care

The report is silent on the issue of outpatient care that is being consistently provided in emergency departments. This can happen with “cardiac cath” patients who return to the emergency department to be monitored and/or discharged after their procedure. The monitoring of chest pain patients, abdominal pain patients and 23-hour observation patients who are held in a clinical decision unit with the emergency department are also not addressed under this domain.

Care of special populations. Consider adding language that addresses the challenge emergency medical dispatchers experience when trying to communicate with non-English speaking populations.

Domain 5: Coordination of Care

Governance and shared accountability. In this discussion, the challenges concerning different rules, regulations and management structure that each State (or local jurisdiction) has implemented must be taken into consideration, especially when dealing with states that border each other.

Handoffs and transition. The addition of a standardized handoff process within the region may assist with accurate measurement of patient transitions. (Please see line 782.)

Communication. Utilization of a standard assessment tool within the region will facilitate better communication between the individual units of care and the region. (Please see line 790.)

Domain 6: Outcomes

Data linkage across settings of care. The Joint Commission cautions NQF regarding the issue of field personnel triaging patients, especially behavioral health patients, to facilities other than emergency departments, especially in areas where mental health provider presence is lacking. Many of the nation’s mental health facilities are closed or are operating at full to capacity. Therefore, emergency departments must hold these individuals for hours and days at a time. If it is difficult for hospitals to triage these patients’ after an initial assessment, expecting an emergency medical technician to find a suitable care is not realistic at the present time. In general, EMS providers lack a sufficient level of training to triage and make disposition decisions regarding these patients, especially to a facility other than an emergency department.

Feedback. Feedback to providers on patient outcomes within the region will assist in their understanding of region logistics and patient transition through the system. This information can also assist the provider with educating the patient/family on the steps that will follow through their care. (Please see line 847.)

Guiding Principles

Patients may be inhibited from pursuing their major preferences by local EMS regulations. For example, measures addressing patient preferences and experiences need to account for whether EMS regulations in a given region allow patient to be taken to his or her preferred hospital (that is, where the patient usually receives care) or must take the patient to the nearest hospital or trauma center. (Please see line 865)

Appendix A

Prevention of further episodes may require measures related to primary or chronic care services in the community, and barriers to access (such as provider reimbursement structures, patient sources for payment, language services, etc. (Please see line 956 in the feedback box.)

Appendix B

The Joint Commission believes that NQF should add a definition for 'regionalized emergency care system' that includes an explanation for what is considered a 'region' and what is considered a 'system.' EMS' currently varies across states and within states, so at least at the beginning of this initiative, parameters will be necessary so that measures can be applied to 'systems' and 'regions' with similar characteristics.