NATIONAL QUALITY FORUM

Moderator: Sheila Crawford
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(Angela Franklin): Hi, this is (Angela Franklin) and I'd like to welcome everyone to the Regionalized Emergency Medicine Measure Topic Prioritization Project. Today's call is focused on crowding and diversion, and this is the expert panel or Group B. And I have with me (Adeela Khan) who's project analyst for the project and I also have with me (Jesse Pines) who's our consultant on the project.

And, Jesse do you want to say a few words?

(Jesse Pines): Sure. I think I know most of you, so, I'm an emergency physician at GW and also the director of the Center for Healthcare Quality there in the Department of Health Policy. And I've worked on crowding, boarding, and preparedness issues for many years.

(Angela Franklin): So, today we'd like to go through a quick roll call and see who's on call and as you introduce yourself, could you also give us a little brief background about yourself, and I'll let Adeela do that.

(Adeela Khan): Sure. Brent Asplin? (Emily Carrier)?

(Emily Carrier): Hi. I'm (Emily Carrier). My clinical background is in emergency management and I am a (researcher) at (technical difficulty) and I've done work related to access to care, healthcare, market, and preparedness.

(Adeela Khan): Thank you. (Brendan Carr). (William Field). (Edward Gabriel).

(Edward Gabriel): Hi. I'm Ed Gabriel currently I'm the principal deputy assistant secretary for Preparedness and Response at the Office of the Assistant Secretary for Preparedness Response at ASPR. My background, I had 28 years in New York City Fire where I was a chief, six years as the deputy commissioner of Emergency Management in New York City, six years as the global director of Crisis Management and Business Continuity for The Walt Disney Corporation.

(Adeela Khan): (Rebecca Khaps). (David Levine). Anthony McIntyre.

Anthony McIntyre: Anthony McIntyre, (start) GW with (inaudible) and I'm more focused on the preparedness element of this. I'm going to have difficulty making tomorrow's call so I thought I would dial in on this one and see how it goes.

(Adeela Khan): No problem. Thanks for calling in. David Marcozzi. Gregg Margolis. (Linda McCague). (Melissa McCarthy).

(Melissa McCarthy): Hi. (Melissa McCarthy) here. My background is I'm a health services researcher and I've done some work on measuring, crowding, and impact of crowding on patient care.

(Adeela Khan): (Ryan Mutter).

(Ryan Mutter): Hello. This is (Ryan Mutter) at the Agency for Healthcare Research and Quality. I am the agency's coordinator for emergency department, research activities, and data development. And unfortunately, I'm going to have to drop off at five.

(Adeela Khan): Well, thanks for joining. AnnMarie Papa. Sally Phillips. (Stephen Pitts).

(Stephen Pitts): Steve Pitts here. I'm an Emergency Medicine Faculty at Emory University where I practiced for a number of decades, and more recently developed an interest in the national surveys particularly as they relate to ER operations including crowding.

(Adeela Khan): Jeremiah Schuur. (Manny Shaw). (Suzanne Stone)-Griffith.

(Suzanne Stone)-Griffith: Yes, I'm here. My background has been the last 12 years, I led quality improvement and performance improvement projects through HCA, Hospital Corporation of America based in Nashville, Tennessee. I'm currently in Denver, Colorado as the vice president of Emergency Services, EMS and Trauma.

I have worked on the ENA Crowding Task Force and measured development group. I've also been participating with the Emergency Department Benchmark Alliance and Measurement, and helped develop our internal ED Dashboard and Crowding Measures for 162 emergency departments that crossed about 20 states and six million visits. So, that's been my life's work.

(Adeela Khan): (Michael Rapp).

(Michael Rapp): Hello. I'm an emergency physician. I'm currently the director of the Quality Measurement and Health Assessment Group at CMS but I'm currently detailed to the Center for Medicaid Innovation. I'm working with the director there. I have background as a practicing emergency physician and director of the hospital emergency department. And also was previously leadership positions at emergency medicine including president of the American College of Emergency Physicians.

(Adeela Khan): Thank you. Cathy Robinson. Arjun Venkatesh. And (Ellen Weber).

(Ellen Weber): Hi. This is (Ellen Weber). I'm an emergency physician at the University of California, San Francisco where I practice for about 25 years. I was the medical director of my department for about 15 of those.

And I do health policy research on largely with regard to ED utilizations, the impact of crowding, and operations improvement and my particular interest actually was that I spent about six to eight months in England over the last few years looking at how they implemented the four-hour target to avoid emergency department crowding.

(Jesse Pines): Well, thanks everyone for spending the time today to speak with us. So, what I wanted to do now is to talk to everyone about sort of the overall goals of the

project and what we're trying to do, and how this is going work over the coming months.

So, this is a project that is funded by ASPR, The Assistant Secretary for Preparedness and Response which is branch of HHS. We are tasked here at NQF to basically put together a document that is really going to serve as the sort of the template and basically the runway for the future development of national crowding and preparedness measures.

So, this is a short-term project. We expect to be done with this project this fall. So, we're going to be a short-term project done this year and essentially, in the – really, the work product of the group is to create a document that details some of the current measures in both the crowding, boarding, and emergency preparedness that talks about some of the measurement issues in both of those areas. And really details how we can get from where we are now in crowding and boarding, and preparedness to NQF-approved measures that could be potentially used for public reporting.

There are some other additional issues that we're going to be talking about on our group, specifically talking about how we reconcile there are really are two communities here, so, there are a number of folks on the call who are crowding and boarding people and we also have preparedness people. And really our – the goal of this is to bring these groups together to talk about measurement in general in both of these areas.

So, that everyone can understand everyone else's world one, and also that we can recognize – that we can reconcile these worlds from the measurement perspective. And then, the two additional areas are to talk about, regionalization of emergency care and also crowd preparedness. And really on the frame on regionalization is about the level of measurement.

Currently, most measures for crowding at least are measured at the facility level. Our thought was basically if we start measuring those at a higher level, for example, at a regional level that we would really create more accountability across systems so especially in some systems, you have a very

competitive market where hospitals may not want to share data or share resources, particularly during crowded or when there was a disaster.

But basically, we start aggregating measures up. You know, we certainly are not going to take the competitive market and make it, you know, and change business model but really what we're trying to do is sort of think a little bit more about (competition) where we have organizations that we know that are going to still compete but also that they are going to cooperate on certain levels towards a shared goal of improved system flow and also improve emergency preparedness.

Finally, our last section is really what we're going to be sort of a practical description of what we think it'll take to move towards national measures in crowing and boarding, and preparedness. And specifically, we're going to be laying out a potential consensus development process for crowding, boarding, and preparedness that could – would potentially take place over the coming years.

Just to let everyone know that project has not officially been funded but essentially, our goal would be to basically define that scope of work for the future and hopefully, folks who have a good time on this group could continue on and – with us on that next group.

But really also thinking about practically about who are the measure developers in this – in the field of crowding and preparedness, and what sort of tools do they need and what sort of issues do they need to consider when creating these measures, and specifically when it comes to preparedness measures, what we're going to be thinking about potentially modifying some of the NQF criteria that we traditionally use in our submission forums for preparedness measures.

And tomorrow, when we have our workgroup call, we're going to be talking about a little more detail about some of the specific issues with preparedness measures. And the example that we're going to give is a recent group that met within NQF to discuss population health, and really sort of preparedness and population health are really similar in a lot of ways, you know, rather than sort

of traditional measures like you know, did someone within specific population get a medication who should've gotten the medication or didn't.

So, there are really some sort of wider issues to discuss there and our goal – one of other goals is to come up with a sort of a change in the standard for measures, for preparedness that would better match the kind of data that are actually available. I do want to say that we don't want to lower the standards but we do plan on changing them to really better fit the content for preparedness.

So, at this time, I wanted to take any questions about the general process and how this is going to go and then essentially the remainder of the call is going to be taking you all through where we are in our thinking on specifically crowding and boarding issues, and also sort of asking you for your expertise of issues that we didn't think about or other issues that you would want to bring up in this area that you think would be important for measure developers.

So with that, any questions or comments?

(Suzanne Stone)-Griffith: Jesse, this is Suzanne. Will the work that's been previously done with the Phase I and Phase II Measure Development potentially be re-examined or modified or incorporated in some way?

(Angela Franklin): Hi, Suzanne. This is Angela. No, our scope is different. We'll be building on that work. We won't be looking back at that work necessarily. We'll be looking at addressing future measures that we'd like to see come into the portfolio.

(Suzanne Stone)-Griffith: OK, thanks.

(Angela Franklin): OK. So, if you'd like to move on to the next part of the call. In front of you or in your e-mail that you received today, there's a draft report summary as well as a draft document for you to refer to. And for the next part of the call, we'd like to walk through that report summary and discuss each of these issues.

So, if everyone has that, I think we'll get started and Jesse will lead us.

(Jesse Pines): Sure. Thanks, Angela. So, really where we're starting here is with the current measures for boarding and crowding. There was an environmental scan that was completed by NQF back in April that included measures of both preparedness and crowding, and identified really a lot of potential measures out there related to the length of stay, capacity within a hospital.

I think the total – yes, we can get the total for you but basically, it's this long, sort of Excel spreadsheet of measures that are out there for boarding and crowding.

Also to remind you there was a 2008 crowding consensus development process through NQF and several measures are currently endorsed and actually would have to go through maintenance and those specifically relate to – or mostly timestamp measures related to length of stay for admitted patients and discharge patients in overall. And also, left of that being scenery.

So, essentially our current portfolio of approved measures, several of those would need to go through maintenance. The other issue to mention is over the last several years, NQF has changed in that the bar for the type of data that you need to get measures through has really gone up. It's gone up on several levels, specifically the level of evidence required to get a measure through and also the reliability testing and the validity testing.

And there's really specific methodology that the NQF wants in those reports, that without that testing you can't get measures through. Specifically for the crowding measures, a lot of the testing will be able to be done in sort of the traditional methodology. When it comes to preparedness, again, we may have to change those standards a bit.

But really, our overall goal, at least in this first part of the report is to take those current measures and then to fit those into what we thought and we want to sort of open this up for discussion is Brent's inputs, throughputs, outputs model as being the frame for this.

For those of you who don't know, this was a paper published back in 2003 by Brent Asplin and several other authors that basically laid out a conceptual framework of the acute care system where it was divided into inputs, throughputs, and outputs. Specifically on the input side that served demands for emergency services and included emergency care, acute unscheduled care, and safety net care.

Throughput factors in general are care for patients in the emergency department, everything from triage, to care and treatment, and also included diversion in the throughput side.

And then output would be issues of getting patients back out into the community or into the hospital. Boarding was included as a throughput measure but also I think it could potentially be an output measure. But really our goal in using a conceptual model is really to take the current measures and then to frame them up on the conceptual model to see where the holes are but I guess the broader question for the group is, is this the right model?

You know, this was a paper that was published nine years ago. Things have changed in a number of ways since then in the world. Is this the right model? Should we think about adopting that for the purposes of measure development?

So, let's go and open it up for discussion.

(Suzanne Stone)-Griffith: Well, this is Suzanne. I will say that while I would be very open to different take on the model, that really was sort of a landmark approach to a conceptual framework and one that I still believe has great applicability, although I think there are other constraints on our system especially on the input side and the output side where those come together in terms of you know, access and medical home, followup care.

And so, I still think it has applicability but there may or may not be a better way to approach that.

(Ellen Weber): This is Ellen. I think that the point you just brought up, Jesse about where does boarding fit in this is the one – is an issue I have now. This is obviously

a great model for talking about sort of the causes and the things we could potentially measure, I guess. But, you know, I think the fact that boarding is now – has moved, in my opinion into throughput as opposed to being the output issue is a little confusing and I think we need a way to kind of think about that using this model.

To me, boarding is really more about the fact that I can't get that patient out. And so, to me, it's an output measure. So, that's just the one place where I think this is hanging up and there may be other examples of that where things that are preventing the output now becomes throughput issues.

(Jesse Pines): OK, thanks. Other thoughts on the conceptual framework? So, our plan you know, was to – so, essentially, I guess the two options for the conceptual framework are the group of options would be to go ahead and use it as is, would be to adopt it in some way or to find a different framework.

What I'm hearing at least from Ellen and Suzanne is that this is at least the right framework and we may want to adopt it a little bit.

(Ellen Weber): Yes.

(Melissa McCarthy): I'm trying to think, Suzanne, the EDM – or is it the E.D. the benchmarking group, aren't you a part of that?

(Suzanne Stone)-Griffith: Yes, EDBA.

(Melissa McCarthy): Didn't they have a model too that –

(Suzanne Stone)-Griffith: Well, I think we attacked the metrics, all the metrics, and Ellen participated on that as well but if my memory serves me correct, I think the conceptual framework was not so much different than what's being looked at here. I think the whole purpose of that was to really look at it in the context of ED to the system hospital. But I think we still approached the metrics in sort of this framework.

(Melissa McCarthy): I guess, I'm just thinking about the input side on the Asplin model and some of this, just not sure how much it helps us in the, like the safety net care

and unscheduled urgent care. I mean, I don't know that we'd able to differentiate some of these.

So, I'm just wondering if something simpler might be more useful to us. And then it could incorporate some of Ellen's comments about, you know, moving the boarding as more of an output measure. As I was trying to remember exactly what that – what your conceptual framework was (Sherry) published right, in annals, right? I'm trying to – I can't remember what that feels like. I know she grabs on figure but I can't remember exactly what it looked like, if it would be helpful or not.

(Suzanne Stone)-Griffith: (Melissa) that does bring up a good point about the input because maybe if the input's an issue but maybe not those particular factors.

(Melissa McCarthy): Right.

(Suzanne Stone)-Griffith: Because I think the idea of the safety net for people who can't get care elsewhere has really expanded into sort of the whole issue of access for anybody to a primary care physician, to a specialist. You know, sort of just a dysfunctional healthcare system.

So, when I look at those three items, I say, "Well, those all make sense," you know? But maybe there's another input issue here which is why you know, why do we need this to keep going up?

You know, we're actually preventing giving more people insurance. You know, there's less trauma. So, thinking about the input and I know that we're talking about boarding but I think if we're going to be talking about crowding we have to at least think about the input issues.

But you know, it's true everywhere that inputs are going up. So, we need to maybe think about at least – I don't know how we – I don't know that there's a quality measure involved but I think in terms of this model, we might want to again, adopt that thinking to maybe different – sort of different subheads.

(Jesse Pines): OK, thanks. And also, to clarify, one of the things that this group could potentially do and if you look at the – if you think about current measures that

we have, most of them are really throughput and output. You know, we could potentially you know, take Brent's model and think beyond that, and think about availability of outpatient services and different way to measure that, that there may contribute to crowding and boarding.

Or alternatively we could think sort of beyond the traditional definition of boarding and think about you know, transfers. Think about, you know, one of the major reasons they come back – people come back to us in the emergency department is because they can't get into outpatient doctors.

So, really our goal, we can think as narrowly or as broadly as we would like to, but I think that, I agree with (Melissa) that really the conceptual model should build what we're trying to do.

(Ellen Weber): Jesse, you bring up a point about the transfers and there's – just fit this in with the other aspects of this work which is the preparedness and the regionalization, the transfers are not really specifically mentioned there but you know, if we go to a more regionalized model of care, then that will affect what the input pressures are. They've, you know, particularly, if you're trying to get stroke in, you've got to move fast.

So it maybe, again, it may be worth at least thinking about what do we – what do we have to be paying attention to on the input? What could we mitigate? What are going to be the problems, and not just totally focus on a throughput and the output?

(Jesse Pines): Thanks, Ellen. I think that was a great point. So, what's the group's consensus? Should we stick with the input, throughput, output model, modify it? Maybe, we can certainly take a look at the EDBA you know the figure from (Sherry's) paper as a potential, simpler model. Any other comment on that or which way is the group going?

Female: Well part of the idea of simpler was just because like, some of this would be hard to measure given the data but I'm not sure that that's the – maybe that's not a good idea to go simpler because we can't measure it. You know what I mean? So, I don't know. I'm having second thoughts about it as I listen to all this.

Female: Yes, you raised a good point. We are looking to fill the gaps in these areas. So, we should be looking at the whole spectrum for making this as robust as possible.

(Stephen Pitts): Steve Pitts here, I've never seen (Sherry's) model. So, I wonder how it would differ from Brent's. Does anyone have a clue?

Female: I'm just trying to find – I'm actually pulling it up as we speak.

(Stephen Pitts): The model seems like a nice – as sort of a set of folders to put your projects in, I don't think it would be restrictive in any way.

Female: Yes. So the – her model is really around just the ED length of stay part of it. It's really very confined to just the ED. It doesn't really get in – you know, so, it probably isn't what we want. You know, when the patient arrives, and kind of different phases of that care until they leave. So, Brent, I think is probably – his is probably better. It's more comprehensive.

(Stephen Pitts): And one of the things that could potentially come out of this as we think about, you know, the runway for future measure development is that we already have the throughput measures and you know, length of stay, and boarding time, and maybe less of that not being seen or what we want. Maybe the focus of measure development could be thinking more broadly about input and output factors.

(Jesse Pines): Great. So any additional comments on the conceptual framework? I'm sorry, next we're going to move on to measurement issues. And in the measurement issues section, there are a number of different issues that we wanted to discuss in detail specifically, to start with the definition of terms – crowding terms themselves.

There were basically two papers that have been published that have defined the timestamps related to crowding, and this was (Sherry's) paper and another paper that I was involved with that was published through the ENA. And I think (Suzanne Stone)-Griffith was also – I think Suzanne, I think you and me were the only people who were on both.

They really looked at defining the specific time increments in the emergency department. The papers were not identical but were similar. Really, the only sort of major difference between those papers and another definition was specifically the boarding time itself.

And recently, we're going to talk about those a little later, The Joint Commission Patient Flow Standard which came out several months ago and it's going to be phased in over the next couple of years defines boarding at four hours after the decision to admit, whereas other groups have defined that – have defined that differently anywhere from two hours to immediately after the decision to admit has been made.

There are some – and I think just trying to understand why the joint commission would want it is four hours, and I think that that was really from input from a lot of the hospitals who sort of see sort of the term boarding as pejorative and they sort of wanted emergency hospitals to have a sufficient amount of time to get – to arrange a bed before they really started using the pejorative term boarding.

On the other hand, from a patient's perspective, you know, once the decision is made to admit, you know, you're waiting and you know, nothing really magic happens at four hours. Really most of the evidence around issues with outcomes really either start – really start at six hours in ICU patients and other papers have defined you know, different cutoffs but there's no real sort of evidence-based cutoff when it comes to boarding where we're above a certain point, the outcome gets worse.

But essentially, at least for the paper here, what I wanted to do is at least have a discussion of some of those issues. The group does not necessarily have to reconcile those terms at least between the two, sort of main papers on this. But to have maybe some consensus of what the group thinks about when the boarding time should start.

So, on the other hand, the argument from the hospitals again was the pejorative description of boarding. On the other hand, you could argue that the decision to admit is made and that you know, boarding time shouldn't be

one minute. You know, there should be some – some specific cutoff above which if that's too long. But essentially, the hospitals would report overall boarding time as defined by the decision to admit to departure.

In the 2008 measures, that was the definition. We did not use the current joint commission definition. But anyway, we wanted to get people's thoughts on where we could stand on that.

(Suzanne Stone)-Griffith: Well, this is Suzanne and I'd like to share with the group a couple of thoughts. While I think various groups agree on the terminology or the definition of decision to admit, the marker for or the trigger for decision to admit probably did not evolve the way that a number of groups talked about it.

Decision, the time that the provider makes the determination in their mind that that patient is going to be admitted is really different than a trigger that, you know, indicates that the patient you know, has an accepting provider on the unit, wherever that is. And we have a complete order along typically with a variety of things that hospitals looked at in order to say, "Yes, this patient is really ready to move."

We've completed, you know, the test to determine that the patient is going to be admitted. They meet those criteria. We've identified the status for the patient. We know what kind of bed they're going to need. And all of – and we have an accepting provider.

And our group talked a lot both at NQF and at ENA and at EDBA that when we have an order to admit the patient, I'm not talking about the admission orders, I'm talking an order to admit the patient that was really a very good trigger. When the measure got picked up, that's really not what hospitals are measuring today. They're measuring a decision to admit, which is in my opinion too loose and a bit of a moving target. So that's one thought that I have for the group.

The other thought that I go back to Jesse is the conversation that the joint commission and CMS both weighed in at our crowding group which was we don't – you know, it goes back to we do slow things slow and fast things fast. And sometimes for the good of the patient, you don't want to incentivize folks

to be moving too fast when we really should slow down and be very measured and ensure that we've dotted our I's and crossed the T's for the safety of the patient. And there was a lot of discussion about what's too long and what's too short.

And I guess, you know, our company has been measuring this since 2007. Every single day on every single patient and every single hospital and we use one hour, not unlike what has been applied to the golden hour if you will of trauma. But it's a made-up time, and it's no better or no worse than any other time factor out there. The problem is we don't know where to say that the cutoff should be, because we've not studied that long enough, broadly enough to determine what are the other variables that we want to assign a time to that are impactful on whatever level.

You know, at whatever access, do our other metrics get affected? Does the quality or safety of our care become affected? Does it impede access at some time? And what I have learned by looking at, you know, all kinds of hospitals from critical access, free standing to large academic centers is that our bandwidth for boarding is dramatically different and different hospitals can handle different volumes of holding minutes or holding hours, depending on how you want to measure it.

So I guess those are my two thoughts related to, you know, all the discussion that various groups have had and where we are now in terms of measuring and reporting that.

(Jesse Pines): Thanks. That's very, very helpful, Suzanne. Any other thoughts and we're going certainly integrate a lot of that into the report?

(Stephen Pitts): Yes, Steve Pitts here. Suzanne, you're saying –I'm not sure if I understood you right, you're saying that what you would prefer to see, and I think I would too, is a measure that depends on some data that are truly available, like when the bed was requested that even though they may not represent the decision time it's available.

But you're saying that at your hospital's somehow the decision time is captured?

(Suzanne Stone)-Griffith: Yes. Our decision time is captured through rather interesting process but – and I'm happy to share that when maybe we're together if you'd like to know more about that. But we trigger our holding clock to start if you will when we get an order to admit.

So our ED providers write an order to permit all of that is variable on a lot of medical executive approved standards. In some places, ED physicians are allowed to write that, in other places. They must have that as a verbal agreement from the accepting provider. And that order has to be what we call a complete order.

It has to include the name of the accepting provider or group that's going to accept that patient. It has to have a status of the patient, meaning we know that they're eligible to be admitted and to what status, observation versus inpatient. And we have an idea of what kind of resources they're going to need in the hospital.

And that order to admit then triggers our clock to start and it also triggers what I would say is a separate process but very integrated which is the request for the bed. So both of those sort of go to two different places and trigger two different events to start simultaneously.

(Jesse Pines): Thanks. That's really helpful. Any other – go ahead.

Female: Yes. And Ellen may be you could speak to this. Do they have different threshold targets for, like if you're going to get admitted to the ICU? Would that trigger a different like you'd want 90 percent of those patients upstairs and X amount of time versus if they're going to a floor? Like I could see some value to maybe the target threshold being different, depending on the severity of patient's condition.

(Ellen Weber): Actually, they didn't and in fact one of the, as much as I think it was, you know, a reasonable thing that they did. They had a 2 percent exception role and so somebody who like needed further stabilization actually would fall into that 2 percent clinical exception and could stay longer, although it really they just used the 2 percent as an (now if), you know. If 98 percent of the patients

got up to the ward on time that was fine and it didn't matter exactly who they were.

So they actually went the other way kind of the people who tended to be the most penalized might be the sickest ones. But on the other hand that was a sort as Suzanne was saying. Those are the people that needed more attention, needed a better game plan, needed to see their doctors in the emergency department as opposed to meeting them upon the floor and so forth. So again, it was sort of a double-edged sword.

I guess my thought on the boarding time is, this is – we've been having this argument where I am which is, you know, it takes us three to four hours to do a mega-workup with patients and then why does it take another four hours to find them a bed. So we felt like it should be bunch of much smaller fraction of the time and, you know, what's the patient centered out come to whether it's simply about comfort or is it about, you know.

We know that the outcomes would vary but I'm sort of in the – I think one hour would make me very happy, but honestly compared to the four hours that the joint commission has recommended, I think that somewhere in there and I agree there's no – I think many of these things we're not going to have, you know, great data, there's just still not – you know there's too much variation in the system in terms of, you know.

Suzanne what you're saying, you need for an order to admit, I have to actually wait four my house staff to write that order. And so the house staff orders, you know, go into my boarding time, right? So if we waited for that, our boarding time would be even longer, because I make a decision, I even put in what I call an order to admit, but our bed control people won't assign a bed until they've seen the orders by the inpatient team and that could take two hours right there.

So we don't want to necessarily, you know, incentivize that the clock starts after inpatient orders are written, which is what we do, you know. I realized that that's a different process, but what I'm basically saying is I think different hospitals have different, you know, who they allow to do what and when they

space start the clock is different. And we may have to figure out a way to kind of get around that.

And I think that's probably why decision to admit the way it has come in. And I know we're having that issue too. You know, if we decide to admit but we don't call the admitting team because we're not sure if it's going to be cardiology or medicine then the teams are upset with us that, you know, they are looking like they waited too long. But on the other hand, we know the patient needs to come in the hospital, so.

(Suzanne Stone)-Griffith: Right, exactly. And you know, Ellen, we've had that same issue. We started back in 2007 with the same issue. ED providers are not allowed to do that. That's the, you know, accepting physician or that's the hospital list. You know, it has been the journey of the ifs.

But, you know, finally at a point we had to separate admission orders from order to admit and we had to say, "ED providers are allowed to do this." It's in their domain and when they write it at least that is a trigger that aligns with that decision. It means I've done all I can do. I know they need to be admitted, now it's up to you.

Now you're right there's still a lot of noise in there. But at least we can begin to look further downstream to try and uncover where the issues are between that time and, you know, getting our bed and moving the patient. But, you know, it's constant.

(Ellen Weber): But we would – I mean, I think even with that we would be, you know, we would still if we took boarding time from an hour after that that would still be pretty good in my hospital. And I this and a lot of others, other ones, you know, if we had a measure that's said does your admitting department, listen to your emergency physicians. That would be a good measure.

(Suzanne Stone)-Griffith: Yes, right. I hear you.

(Jesse Pines): Great. Thanks for that discussion. So if there are no other comments, we'd like to sort of move on to our next section, which is on data sources.

(Melissa McCarthy): Jesse, could I would just raise one other thing on the measurement?

(Jesse Pines): Sure. Go ahead (Melissa).

(Melissa McCarthy): is this the extent of our measurement problems or no? What this paragraph – these two paragraphs here on the report? Because I'm just – you know I was just looking back at Brent's model about like all this input stuff that we don't have a good handle on except for like the count, the total count of how many come through the door.

But I wonder if you should just have a paragraph about, you know, that we can't measure some of these things like how many can't get into primary care, how many have access barrier? I don't know, I think it is very problematic because the conception is that the EDs are inefficient or that the wrong people – people are using them for the wrong reasons? You know, we shouldn't have all these visits.

But in actuality, you know, it's not that. You know, we're trying to be as efficient as we can. We're very overcrowded because we're so popular.

(Ellen Weber): We do such a good job.

(Melissa McCarthy): Yes. And actually the better job. You do the more then you're going to get right.

(Ellen Weber): That's right. That's exactly right.

(Melissa McCarthy): Then they realized that you're efficient and then even more people come. And so it's like you just can't win. But I wonder if there's such a misconception out there about what the problem is that I'm a little frustrated that we can't tell. The public doesn't know what the problem is and I'm not sure if we're going to capture it here. You know what I mean?

(Jesse Pines): And I agree with that and I think that's – could be a good addition to the report that we could talk about the elements of the system that we can't measure. And, you know, really the goal of the group is to, you know, to

come up with a consensus of what we think, the potential measures we can develop, could be potential measure also for the future.

So this consensus development process is typically about two to three years. A lot can change over that time is terms of what data might be available. So we can certainly put in there what would be things that we think should be measured or if a data became available such as the availability about patient appointments, you know, government has moved away from secret shopper studies as a way to collect data. But there are, you know, this is a concept's piece so really it's up to the group what goes in there.

(Michael Rapp): Jesse, this is Mike Rapp. I just want to comment a little bit on the boarding definition and that sort of thing? So to me the measure is the amount of time that it took between the decision to admit and the time they left the emergency department.

This definition of boarding occurring once in hours passed or four hours is passed, there's not so much a measure. It's a standard of that one who would inspire to or consider the benchmark that people would try to reach. So I think there two separate things to the level of point.

(Jesse Pines): Thanks, Mike. OK, just – yes go head.

Female: Jesse – before you go on, Jesse, we didn't talk very much about the 71 measures. Is that part of our charge going to be to narrow those down to make some recommendations?

(Jesse Pines): Not really so. So essentially we have two separate sources of measures that are going to go under current measures. One is the environmental scan, which includes several, you know, there's a good deal of overlap with flows in the systematic review and what was the main environmental scan.

So essentially we're not going to really recommend specific measures in this process. This is really to come up with overall measurement issues that measure developers should know as other major developers which may include some of us on the call. Certainly, we want to know when actually developing these measures.

We could potentially prioritize specific types of measures, so one of the major issues as you know is measures in the ED as you have sort of flow measures and non-flow measures. Measures of flow would be things like length of stay or boarding time or how long it took to see the patient. Whereas measures of non-flow would be measures of things like occupancy or waiting room number.

You know, in my opinion and also, you know, just to move on some of our measurements that's here, you know, with those being the big, the two big categories along with maybe a third category like toll accounts like the number of left without being seen, you know, and maybe that's where some of the other input issues could come in where we would look at, you know, the total demand for emergency services.

But really looking back to the 2008 panel, there's really the overall length of stay and those types of issues that did make it to the process whereas issues like occupancy, which is really sort of a minute to minute measure could not necessarily be, you know, may not meet the NQF standard.

There are some ways to measure occupancy. Hospitals measure occupancy at midnight. The paper that Melissa did were also worked on and looked at sort of within day variation when they came to crowding and the between day variation. And this was I think related to a project that Ryan was working on. And I think what we found and (Melissa) you can maybe clarify this as we found that within day variation was about tenfold higher than the between day variation.

So when we look at issue like counts, like volume on a specific day that didn't capture a lot of the variation that you would see within a day. So, you know, within a day what it looks at 2 in the morning is very different than it looks like at 2 o'clock in the afternoon. But I don't know if (Melissa) you want to say anything more?

(Melissa McCarthy): That's good. That's good, yes. This is a lot more variability in crowding within a day than across days.

Female: Yes.

(Melissa McCarthy): Great.

(Suzanne Stone)-Griffith: Absolutely.

(Jesse Pines): Great. Any other comments on definitions? And I'd like to move on just so we can get everything that we need to do today.

So the next is data sources. And essentially what we have for data sources, there are a number of different ways to capture crowding data to time stems in electronic. House records, that's probably the easiest way to do it. Over the coming years, more and more places will be on electronic systems where you will be able to capture that data, but not all hospitals have that and a lot of hospitals still capture data with paper, the paper time stems.

There are a number of other ways to potentially capture crowding data particularly if we – if we aggregated at the level of the day such as some of these input issues of, you know, looking at the total number of patients in a day who came to the emergency department, you know, other administrative data like the number of left without being seen.

But really, those were the major things that we could think of in terms of potential data sources and really are sort of data sources paragraph is going to focus on some of the potential data sources that in current measures if we do want to include what future measurement might look like, we could potentially expand beyond that to looking at primary care capacity or other different ways to measure that. But I wanted to see what people thought about other data sources that might be available for – to measure these concepts.

(Stephen Pitts): Steve Pitts here. You know, I would say that the less data the better if focusing on compliance really. I mean, if you can get the time seen on 100 percent of your visit that's miraculous. Just you know, having just 5 data points like time of arrival, times seen, time of decision, time of leaving the department and then a couple of other items like admission status, et cetera. If you can get those 10 items on a large scale, that would be pretty incredible.

Female: Do we know, I mean, I know there's only, what maybe a third or a little bit more that have a comprehensive information system in EDs. But don't most EDs at least have an electronic patient tracking system where they at least capture when people arrived and when people leave?

(Suzanne Stone)-Griffith: We usually have a registration system –

Female: Right. A registration –

(Suzanne Stone)-Griffith: So that's usually I think most places would have a computerized registration system to capture arrival time and then how they put in the departure time may depend on, you know, where did they extract that from, a track board versus a, you know, the nurses discharge, when they sign the discharge instructions.

Female: Right. So we'd at least have arrival, some arrival and discharge date pretty much.

(Suzanne Stone)-Griffith: Yes. I would think we would have length of stay.

Female: Yes.

(Stephen Pitts): If you have time seen, then you also have the waiting time with the treatment time segregated.

Female: Right.

(Stephen Pitts): Which should be very useful, I think.

Female: Yes. If you have, you know, if you have a track board usually you'll get that.

Female: So we do have measures because for that reasons that have been endorsed on those two –

Female: Right.

Female: Right, right.

Female: Well, actually the door to provider measure is somewhat problematic, because apparently the door to provider is not going to be satisfied by the time you signed yourself up to the tracking board. And that's the problem, because most places that's how they measure it.

(Jesse Pines): And also just to as a point of information. So the door in the 2008 panel I think – I'm pretty sure (Brandon) was on that panel so maybe he can comment offline. Door to provider time was not endorsed. And I was not in that panel but my guess would be because of issues with reliability of actually capturing the information.

Female: But isn't there now a door to provider time?

Female: There is a door to –

Female: Coming up with –

Female: Breathe time, yes. The door to doc.

Female: There's a door to doc time for the upcoming measure, the ones that are already in place, right?

(Stephen Pitts): For the CMS measures?

Female: Yes.

(Stephen Pitts): I'm looking at it on my screen here. That's why I mentioned it, because I don't see it here.

(Jesse Pines): Yes. I think the door to provider time and we look at this we refer to recent paper that door to provider time was one of these measures that got pretty far through but it didn't end up making it all the way through. And I emailed (Brandon) about maybe about a year ago about that and he did confirm that. But we can sort of reconfirm that with him and also I think we can probably also check internally. But I don't think that door to provider time is one of our current endorsements measures.

(Ellen Weber): We just had a big discussion about this at a QA meeting so I'm going to have to look again.

(Ellen Weber): I know – this is Ellen. I know there's something because I know where (my heads and practices) they have been having to – they have to right manual notes to indicate that the patient must be seen by the (initial contractor) that this isn't such time, because just signing up for the patient was inadequate. For now, I don't know for what quality or reporting program that was, but somewhere –

Female: Maybe it's the doctor's decision time and that's why you need the doctor. It might be – is a doctor to decision time, that's why you need the doctor time? I don't know, but we could look at that.

(Suzanne Stone)-Griffith: Yes, I know. We have been collecting and reporting that. I was under the impression that it has moved forward.

(Jesse Pines): I will – we can certainly look into that and confirm that and get that back to the group.

(Ellen Weber): Jesse, one other thing, and I don't know quite whether it would be correlated or just simply something to know if hospital occupancy data which I don't see here because this is actually something we came up across in that last health affairs article which was, you know, people are saying that, you know, boarding is occurring because the hospitals are crowded and yet the data we could get from the American Hospital Association, that was the only place we could find it basically showed an average of like 63 percent hospital occupancy.

Female: Right.

(Ellen Weber): So, it would be helpful if there are ways to actually get that data from individual hospitals. You know, require that to be reported in some way or if certainly – I don't know if that's part of the measures or whether it's where we get it, but that's a difficult, you know, it's a difficult number to get, and I think it would really be informative.

Female: Right. And really also, it's even more complicated Ellen, too, because you know, some of those words are not at all really relevant to the ED.

(Ellen Weber): Yes.

Female: But in total hospital occupancy they get reported as part of the overall occupancy, you know. So, you really want certain words where you admit to. So, yes and some hospitals just measure it like once a day, it's just, you know, a lot of issues around it.

(Ellen Weber): Yes.

Female: But you're right.

(Ellen Weber): Somehow they get us – somehow the American Hospital Association gets some number, you know.

Female: Right, right.

(Ellen Weber): And I – and it reflects the fact that this is – that perhaps – potentially boarding is not because the hospital is full.

Female: Right, right.

(Ellen Weber): They might be inefficient, but they, you know, may not be full.

(Angela Franklin): So, I – this is Angela. I have just a quick point of information, actually from (Stacy Jones) over at (ASEP), thanks (Stacy) that the door to doctor measure still on the hospital outpatient measures program but it did lose NQF endorsement earlier this year.

(Suzanne Stone)-Griffith: What has that mean?

(Angela Franklin): So, it's still on the outpatient – in the outpatient rule.

(Suzanne Stone)-Griffith: OK. Right.

(Angela Franklin): But it has not – it does not have NQF endorsement at this time due to testing.

(Suzanne Stone)-Griffith: Yes.

(Stephen Pitts): Outpatient meaning, ER?

(Angela Franklin): Yes, that's correct.

Male: OK.

Male: What that means is then the hospital outpatient reporting programs, patients that aren't admitted to the hospital, that are in the Emergency Department and the CMS can use measures (without) regard to whether they're NQF endorsed. If there's no NQF endorsed measure on a particular topic, then CMS can use the measure and on the other hand just because the measure loses endorsement doesn't mean CMS has to remove it.

Female: Right.

(Jesse Pines): So, for this data sources paragraph, thinking more broadly about input or output measures that for data that we might want to get and certainly occupancy which was I think if measured at midnight by the hospital can does really sort of capture the intraday variability. Are there other sort of big categories of measures that would want to have sort of –in our ideal world?

Female: We don't have an acute – for example acuity would be like if we were all standardized, and I guess NCHS manages to come up with the triage measure that – but we don't even have that, right. It's kind of apples to apples across all hospitals.

(Stephen Pitts): That's a huge thing I think – I think that basically the US has got all these different schemes include ESI and the Canadian rule and then some people use their own homemade rules. NCHS can only capture what people give them. So, they don't have any authority to tell people what to do whereas CMS does and that I think that would be incredible thing if we could push for something more uniform like the Australians have. If that would enable us –

Female: Right.

Male: -- to sort of severely adjust these visits even though I know those triage categories are gameable.

Female: Right.

Male: And also –

(Suzanne Stone)-Griffith: So they're not only gameable but they do really changed potentially, right? I mean, we might say you that have come in with chest pain, I'm going to make you a two, but after we do your EKG and your troponin, we find out that, you know, it really isn't cardiac of nature and med you are a lower acuity.

So, even you get admitted you might not need that CCU bed, you might need a med-surg bed or you might not need to be admitted at all, but some combination of front-end to acuity with back-end either bed request – bed type or right now the surrogate E&M level and typically physician E&M level has been more reliable than the hospital because of the diversity of our, you know, billing processes might be very interesting to look at.

(Jesse Pines): Also as a point of clarification so, the Canadians have a standard, so some which is called a CTAS, the Canadian Triage and Acuity System and in their time targets that's how they actually stratify their time targets by acuity where the higher acuity patients – the time target is eight hours whereas the lower acuity and I don't know exactly what the cutoff is but the lower acuity folks should be out by four hours.

Female: Is that a reason change Jesse because the – when we were looking at that we really looked at the acuity related to this time they should be seen by the provider upon arrival? So, now have they added when they should also be placed or be out of the ED?

(Jesse Pines): Yes, this is I think relatively new. This is the new – the new Canadian time targets, and that we can – to send the reference out to the group.

Female: That would be great. The other thing is acuity may not be the number. I mean, again, it depends on what you're looking at. If you're looking clearly –

if you're – if you're just going to look at boarding time and acuity is absolutely right because you want that higher acuity person leave sooner.

In terms of total stay, they'll complexity maybe more of an issue than acuity. I mean I can get my (casp) person out in 25 minutes and they are the sickest person in my department. So, we have to make sure you know when we're talking about these measures what we're applying – which time frame we're applying them to.

(Blake): Jesse, this is (Blake) without regard to whether it's a good way to do or not, how do the Canadians – do they – do they get the Emergency Departments to sort of capture triage acuity in that way on a standard basis and how do they do it, and if we were going to try to do that in the US, how will we do that?

(Jesse Pines): So, I don't know a whole lot about that, but I do now a whole lot of details in terms of how they roll that out, but I think that – I think all the hospital in Canada are on CTAS, the Canadian Triage Acuity System. I don't know precisely how that rolled out but what we could do is to look into that and get back to the group.

You know, some of the other ways to measure acuity were also mentioned on the call so the CDC basically looks at the time – the suitable time before a patient should be seen which is batched into several I think four or five broad categories depending upon the year of the CDC data, like Suzanne mentioned that the E&M code could be potentially a proxy for severity or certainly what was documented for an outpatient visit, but we can look into the CTAS and how that was done and send something out to the group.

(Stephen Pitts): Yes, I think maybe part of this project it might be worthwhile to figure out if something like that would be recommended or people could gravitate around one and that way – but I think that it should because the next step is how you get hospitals to do that, but I – it could be incorporated in some kind of a measure and the measure be based upon some standard way of collecting.

So, the measure in might kind of bootstrap the data collection but since hospitals don't standard – standardly collect that but it does seem to me, and I'm familiar somewhat with the Australian use of the similar triage scale and

that that they use it to determine allocation of resources and things like that. So, I think it would be useful and possibly if this – in this project one should come up with a recommended scoring –

(Suzanne Stone)-Griffith: There was a, you know, a collaborative between (ASEP) and (ENA) some years back and they went through a review in the hope that they could come up with a unified recommendation for this country. At the end of the day, the group ended up saying that the highest reliability, validity of the systems were the ESI and the CTAS and what has really taken off in there were strengths and weaknesses at that time of both systems. I will say, our company said, "We don't care which one to use but you have to use one of those."

And as time has progressed, ESI has gained more and more strength at least in this country with additional research and versions and that now is offered, you know, free through AHRQ website to pull down that information and to do your training from there. There's also a difference in your training cost, so I don't know if maybe that's something that, you know, this group could handle or even, you know, recommend that the original collaborative should come up with that recommendation.

Male: Yes, well, however, that is just a matter of getting something standardized that everybody uses rather than one or the other because they're not – I'm not sure convertible, but anyway I do think it would help advance this – on being a somewhat because right now the measures are just – there's no adjustment if you will because there's no – there's no adjustment on basis of the acuity or anything else for that matter.

(Jesse Pines): And also there was a recent paper in academic EM but I think (Megan McCue) is the first author where they looked at triage scales across the US and found that ESI is actually the most prevalent triage scale and, you know, also like Suzanne said the most reliable.

(Suzanne Stone)-Griffith: And I think really for our group sort of focus, you know, they – that acuity method did sort of differentiate itself from CTAS – CTAS in terms of predicting the admission. Utilization –

Male: Yes, so –

(Suzanne Stone)-Griffith: -- of resources predicting the admission which is sort of where we're headed.

Female: What I like about it over coding is that you can game, you know, you're trying to bill – your coding is related to your billing and that's where gaming occurs, but I think that the front-end of the door people are triaging. I don't think it's about trying to game, you know, I think there's less of that going on because it is not tied to the billings so like –

Male: Right.

Female: -- we rather see us put our resources there than on the back-end I guess we have to choose.

Male: Yes.

Female: I guess I would just start look at the real issue – a bigger – our biggest issue is we're talking about boarding is the unit they're going to and how sick they are.

Female: Yes.

Female: And if somebody comes in as a two and then basically has atypical chest pain, they may get admitted and they're going to wait for a really long time and that may not be a fair representation of how sick they are and the priorities of the department or of the hospital. That's a sort of getting back to the original question in the list which is, you know, should we be basing it on, you know, the care – critical care unit they go to or the type of unit they go to as the risk adjustment.

And the thing as their reason – there's three, you know, as we know –

Female: Right.

Female: -- so, I'm not – I have trouble with ESI because of that. I don't think it helps me as much as it may help, you know predict admissions but I just think we ought –

that's another way where we don't actually need as much standardization in triage. If we cannot get at –

Male: Well I'm not –

Female: -- the award you're going to –

Male: I'm not talking about connecting enough with the boarding per se, just a matter of kind of being able to describe the nature of the patients who come into Emergency Room.

Female: Yes, more on the input side. Right, right. Because there's level five –

Male: The other thing that –

Female: Yes, go ahead, sorry.

Male: The other thing, Jesse, you were talking about bed occupancy. What – were you talking about the Emergency Department or are you talking about the hospitals?

Female: Hospital.

(Jesse Pines): Yes. The hospital does measure that in the AHA data.

Male: Yes.

(Jesse Pines): But, you know, again, we could also make that same recommendation for something like census or another measure of that in the ED.

Male: Yes. So, that sort of just kind of follow-up on a little bit because the Emergency Departments do have a bed number just like hospitals do. But frequently they have more beds than their bed number so that might be a way of, you know, at least some description of the crowding if you did that snapshot at a certain point in time that the standard or maybe a couple points in time.

Female: Since we're talking about a wish list. How about some measure of whether the patient has primary care access or like, I know a lot of times you guys ask, "Do you have a primary care doctor?" So that is being recorded at fair amount of the time because that gets at both input issues and output issues.

And it ties us a bit larger system which, you know, we don't really measure well right now or how well our patients are tied to the rest of the system. You know, so is that too far of a stretch?

Male: Not – yes, not necessarily, I mean, we can certainly put that in there. One of the issues that we had at least when I back at (PAN) is that particular field in the – in our EHR was the most unreliable field. A lot of times, the wrong name was in there, you know, a lot of times patients didn't know who their doctor was or they would identify a sub-specialist as a primary care doctor. So, from a measurement perspective that may be problematic, but it doesn't mean that we can't put in there as our wish list.

Female: They have – even you mentioned this already, when they report hospital occupancy, how granular does that get? I mean, could you know – I mean, what – I'm most interested in, you know, can a patient get to the OR in a timely fashion or can he get to ICU or (step down)?

(Jesse Pines): So, one of the thing that – one of the things that differentiates like (Mike) was saying that sort of ED occupancy versus hospital occupancy. So, hospital occupancy is based on the number of licensed bed they have in the hospital and the number of people who are in that hospital at midnight. So, you got – you actually can sort of calculate an occupancy rate. When you look at an ED, you have a number of – a number of registered beds but you also as, you know, may have some hallway spaces, you know, patients are moving to internal waiting rooms.

So the idea that, you know, who's really in the – who's really an occupant and who's not an occupant. Do you include the waiting room people, you know, there a lot of different models that would sort of count, treatment spaces differently. Steve, how does the – how does CDC handle that?

(Stephen Pitts): Well, first they don't – there's a rule. There were two – there were two years '03 and '04 when they asked how many standard treatments spaces do you have? And they meant stretchers and then they asked how many non-standard treatment spaces do you. And that second item was not reliable on my – in (my look), but the number of standard treatment spaces was probably – this is not – it was probably – represented the number of you know, rooms numbers on them, and I think that number might be reasonably reliable.

And I think it would a justifiable just to look at that number because the more stress you are the more non-standard spaces you're using, and I think it's a very worthwhile, but – it is key to developing this concept of the occupancy rate and, you know, I'm actually looking to that on a national level right now in a data set in the (Hampser's) data set and there quite a few ERs that have a main occupancy greater than the number of standard treatment spaces like 20 percent.

So, that means they're always on average have more patients than beds. It's a statistic you could probably get just by knowing occupancy and by knowing the number of bed spaces – standard treatment spaces.

Female: But I mean, I think your point though – I mean I think with the capacity at different hospitals varies in terms of like how often you can get the measurement like it happens for example, you could get it hourly, at GW you can get it maybe once or twice a day.

So, I think it just depends how – what kind of system the hospital has in place. I also don't know I think some hospitals differentiate between licensed beds and staff beds.

Male: Yes.

Female: And I don't know, you know, the CDC reports all this out in some of their reports since I don't know when they – I don't know what the AHA uses like Ellen when you looked at their statistics it's about 60 percent.

(Ellen Weber): Yes.

Female: I don't know if hospitals are reporting – and that's kind of the average daily over the whole year.

(Ellen Weber): Yes.

Female: So, I don't know if that's using licensed beds or staff beds because they can be different, too.

(Ellen Weber): Right. I agree. Yes, I mean, because – I mean, it's true you could say that they are occupied, you know, they are 60 percent occupied but if they can't get the staff, what's, you know, then you really it's not – it doesn't matter if they can't move the patients up.

Female: Right.

(Jesse Pines): Great. This has been really great discussion. So, any additional comments on data sources that we want to mention before we move on? Got a few other areas to hit.

So, next then I want to talk a little bit about risk adjustment. Risk adjustment is something that is used for a lot of different NQF measures, particularly for mortality measures and another, you know, another outcome measures.

There's a question about whether we should be risk adjusting crowding measures. We did a paper that came out in the last few months that looked at the current NQF approved measures and actually found that a lot of different factors predicted things like length of stay and for that being seen rate things like case mix, ED volume, whether or not MSA, you know, where it was in the country.

So there were a lot of these sort of exogenous factors that are arguably outside of the hospital's control that really predict a lot of these measures. So the broad question for the group is, should we be recommending risk adjustment when it comes time targets? I guess, the other argument would be, when the patient comes to the hospital 30 minutes or 30 minutes, it doesn't matter if they're at a big intercity hospital or their over a hospital.

From a patient perspective, they sort of perceive that the same way. So, when it comes to performance measure, should we be giving hospitals a pass for certain factors that they can't impact like a physician can necessarily impact, whether their heart bypass patients are maybe more likely to die, and just maybe the patient's they operate on. So, I wanted to see what the groups thoughts are about risk adjustment?

Female: Does this eventually get tied to payment, in some ways? I mean are hospitals going to be penalized if they're not meeting certain thresholds? Because then, I would argue that you have to risk adjust. It's just totally unfair to hold, you know, hospitals that don't treat the same case mix and vulnerable populations with the same target. You know, unless you're going to pay them a lot more for treating you know, harder patients.

(Ellen Weber): So that why, I would take the other (humus) which is that as Jesse said, I mean, that if you have that kind of patient population, you have to dedicate the resources to them. And you know, maybe, this is actually something, and a lot of departments would want in a sense of going, yes, you need to give us you know hospital, you need to give us more resources and more space, more something.

You have to get our patients out quicker, because they're sicker. I worry about, you know, again, the opportunity for gaming if we do that type of risk adjustment. And then, there's other things you could, you know, if you did that I would argue, "Hey, I have a legal nursing ratio of four to one in my department." And that means that I – if you know, there's more – too many people in the waiting room, the nurses aren't going to bring them in. Well, you know, the goal is for me to figure out how to handle that with the volume I have anyway.

Female: Just to answer the earlier question, yes, we would be recommending measures that would be used for accountability.

Female: Because right now, really, what happened it seems to me is that we – hospitals are still like – I don't know to what to extent, but I think a lot of the hospitals

in the intercity are – they don't, there's a lot of uncompensated care that they try to get their money back from the patients that are paying, right.

It's not a great system. I just worry.

Female: Well, I agree with you. It's not a good system.

Female: Right. The less of that being seen rates are higher. They're slower. Yes, I don't.

Female: You know, I mean, I think there's been – Jesse didn't the (Renee) recently come out with a paper like a year ago?

Female: Right. Just recently, (Renee) came out with a paper saying that at least it was for the current measures, that there is not a problem for the safety in net hospitals.

Female: There's not a problem with –

Female: Therefore, they would not be penalized by the current safety net measures and I forget why, but they actually looked at that, because that was the first thought that the current you know, door-to-doc and door-to-discharge would be worst than safety net hospitals, but they didn't find that to be the case.

Male: And so I guess so.

(Jesse Pines): Yes, there's this sort of broader question is, if we are going to recommend risk adjustment, what to use for risk adjustment because at least in the paper that we did, we did not include, you know, certainly if you include proportion of racial mix within a hospital that is predictive. We had chosen not to include that at least in our paper when we were trying to create a sort of a simple stratification system which we couldn't do just because there were too many factors.

But we said explicitly that we were not going to include things like racial mix because then, we would say that we're giving a pass to hospitals who see higher proportions of a you know, certainly, if you see more trauma patients

that should you know, that may change what you do. But if you see more black or white patients, should that really change how fast people get through the system?

(Mike): Jesse, this is (Mike). In general, I would think when the outcome measures are risk adjusted it has do with patient factors like comorbidities and that sort of thing. And it deals with the clinical outcomes of the patient. What we're talking about here is what the hospital is doing in terms of organizing or sharing that sort of thing. And it seems to me that if you can predict the situations that they're going to have trouble with that, then the job is to put the resources on – in other words these outcomes are controlled in the hospital I think for the most part.

So, despite the fact that you can associate certain factors with longer – makes the stay and that sort of thing, I personally won't be in favor of risk adjusting these.

(Jesse Pines): I just like to clarify, so you are not in favor of risk adjustment at all or risk adjustment with patient factors such as race?

Female: I don't think it's race.

(Mike): No, no, no – definitely not race.

Female: Yes, definitely not race.

(Mike): No, what I'm saying is I think the ability to take care of patients in an expeditious fashion is the biggest factor is how – whether you put adequate resources to do that.

Female: Yes.

(Mike): And if you don't, you're not going to do it. And so, I think that – personally, I think that's the biggest factor. And I think these – to the extent that you have a population that may take more time, it seems to me that's the job of the hospital to put more resources to do that. So, I personally, would leave risk adjustment alone.

Male: And it seems like the previous measures, there's been a sanction for failing. And you're saying basically, that if you fail you should get more resources.

(Ellen Weber): No, not you should get them, but you – it's your, you know, if you're hold – my argument as if you're holding yourself as an emergency department that gives quality care, then you have to justify why – if we think that time in the department or length of boarding is related to quality of care, how can you say that you deserve a buy just because you have more complex patient population?

You know, I would – we would want to argue that too. And I think a lot of people – I know in England, a lot of people said the same thing. But in the end, you know, it's up to the hospital or making the case with the government that you need more support to handle this. Now, you – it's possible people would game it to get more support first, you know and then do well, but there is – there is an embarrassment factor here.

And I think risk adjustment just is sort of obviates the whole question of what if this is quality, it's quality.

(Suzanne Stone)-Griffith: But should there some adjustment and maybe risk adjustment isn't the right term for this going back Jesse of what you said, are we talking about patient or something else. I mean, what we've learned from measuring this over the number of years is that I have some hospitals that at 200 holding hours in a month or 300 holding hours in a month really beamed up the floor begins to affect other important factors like the walk-away rate, like the door-to-doc times, like the – and we haven't really been studied quality outcome.

But, there should be some other factors. So there is – and yet, I have other hospitals just because of size, other resources that they may have had create a ways they may have approached it, staffing a variety of other things. They can tolerate 1,000 hours of holding a month. And none of their metrics, none of their quality metrics are affected.

So, there is some sort of threshold that potentially could be applied to different organizations. But it's very multifactorial. I don't know how you get to that, other than on an individual basis. But I think there is a difference.

(Ellen Weber): Well, Suzanne, maybe that argues not so much for risk adjustment, but for a bundle. You know, for instance, you know, if there is certain measures that measure your length of stay, and other measures that measure your quality or patient satisfaction, or something. And you can show as a hospital that yes, you're not meeting this length of stay target, but everything else is as good or better than another hospital.

You know, that gives you not a buy. It's just one of the measures where you have to say, yes, we do hold people longer but it doesn't make a difference. So, rather than a trying to adjust for that on the outset, maybe it's that we have to look at more than one or you know, more than two or three measures.

(Suzanne Stone)-Griffith: Right. And it really becomes a factor of the lengths of holding per those admitted patients.

Female: Yes.

Female: I guess I would –

(Suzanne Stone)-Griffith: Because if I hold everybody 12 hours versus I hold everybody two hours, I have way more capacity for holding.

Female: I guess I look at it more like – we want to compare across hospitals.

(Suzanne Stone)-Griffith: Right.

Female: You want to compare like hospitals to each other. And so, you have hospitals that have just a high Medicaid and uninsured population.

(Suzanne Stone)-Griffith: Yes.

Female: And I think their length of stay is going to be different, you know, and maybe, you know, in that group of hospitals that have low performers and higher providers, I'm sure used to have a lot of variability. But to me, they're – they can be very different potentially than hospitals that have a very different payer mix. And so –

(Suzanne Stone)-Griffith: And you see, I agree with you up to the point of when I make a decision. So I do think that a complex patient who doesn't have routine medical care and doesn't have access, and comes in multiple times with a variety of complaints becomes much more challenging to determine what we should do for that patient.

But once I make the decision of what I should do, to me, how we move that patient in our system should not matter. Whether you're you know, have insurance, don't have insurance.

Female: But it does, I mean, I think some of these inner city hospitals, that's why they have social workers that are actually working in the emergency room, trying to figure out how they're going to get this patient's prescription medication that their patient needs. I mean there's all kinds of reasons why these patients can be, you know, more time consuming. I don't know.

Male: Yes, I agree with that. It's just complete day and night difference between –

Female: Yes, you might admit that patient just because you don't know, you know, he doesn't have the access to go home, whereas you might send the next patient home because they have good social support. I mean, there's just – I don't know.

I worry a little bit that if we don't try to do some – if we can't, you know, if we could – I think the ideal situation is we try to measure some of these patient factors that result, you know, or in some ways make the care more complex. So the resources needed to care for them, you know, more demanding, more challenging.

(Suzanne Stone)-Griffith: Well, I don't disagree with anything you've said, except that I thought in the context of boarding and making the decision when we're going to begin to say you're holding for admission. To me, that isn't any different. For all those other factors, I agree.

Female: I'm just thinking you know, like even some of the measures that have already been approved like length of stay –

(Suzanne Stone)-Griffith: Right.

Female: And even if you just look at like admission rate.

(Suzanne Stone)-Griffith: For discharge –

Female: Yes, by hospital, some, you know, some hospitals have much higher admissions –

(Suzanne Stone)-Griffith: Right.

Female: I just think all these things matter.

(Suzanne Stone)-Griffith: Well, they do.

(Jesse Pines): So, I'm not hearing a – sort of a clear consensus on this. So essentially, I think what we're going to do for at least this section is to sort of describe the issues and the pluses and minuses. And then, when we have our in person meeting, everyone will have a version of the report to edit and can, you know, we may not have a consensus on this. But really, we may just end up describing the plus and minuses.

So, we have a little less than 20 minutes left here. There a few other areas I did want to hit specifically, I think a big area is time targets. And I know Ellen, you've done a fair amount of work looking at time targets. I know that the UK has moved away from that, I think back in January.

And really, the question is should we as a country be moving towards time targets or not or should our time targets in general good, but maybe four hours is not long enough particularly for more complex patients or are there just general issues with our intended consequences like Ellen's paperwork. People sort of get shuffled around in the last 20 minutes.

(Ellen Weber): So, I'll just speak to what I, you know, I think there are risks to the time targets. And one is the fact that it's an absolute – if there's an absolute cutoff. Then what tends to happen is either there's gaming towards a certain target and yes, you said, the last 20 minutes everybody was running around.

And then, after that target's over, nobody cares. Because you've reached the target, you've reached the target. So that's a downside. And as I mentioned also, that you have to have some availability for people to not have to meet the target and unfortunately, the result sometimes in the sickest patients remaining in the ED. Although, I'm not always sure that's so bad.

On the other hand, the – what they – the time target, if it is reasonable and if the hospital is held accountable for it. That was a huge boon to all emergency departments in getting rid of crowding. And the idea – what basically wound up happening in England and is probably happening elsewhere as well is that the patient's they wanted to keep longer, they found a way to keep longer. They had a clinical decision unit and everybody went into that and if you wanted to rule somebody out, you could do that.

In fact, that was sanctioned by the NHF. So, the importance of the time target is what it mostly got at was boarding. If there's another way to get at boarding, if there's a time target specifically for boarding, then you don't necessarily need a length of stay target. And that, to me, that would be a better – a boarding target would be a better one because it doesn't penalize the ED for the more complex patients that take some time to work up and make a decision for.

And it also doesn't send the message that it's bad to be in the emergency department for more than X number of hours, because after a while, it's starts to be well if even one hour of a good time. So, I'm a little bit torn because I feel like the board – a boarding target may be harder to implement in terms of when this boarding start, then you know, and so forth. But the time target for length of stay is a bit of a blunt instrument.

(Suzanne Stone)-Griffith: Well, this is Suzanne and I come from a company that is rich in terms of measuring and setting targets. And over the course of 10 years, by setting those targets, we certainly have worked towards improvement. So, while targets I think help us all, you know, work towards them. They do, to your point have some unintended consequences. People do want to gain them because they want to put a check in the box or get an A plus, and not actually do the work required.

I agree, Ellen with you that boarding might be a better metric or to use it in the context of some type of bundle. I worry about the unintended consequence of removing length of stay where now, all of a sudden, it would be acceptable to have continued push where the emergency department becomes a place to work up and diagnose a patient as opposed to really disposition the patient.

And I think over the years, you know, I think we've morphed to more and more to try and finding out what's wrong with the patient, so that when we hand them off, we're not doing in the hospital space as much. We're doing that in the ED and that is affecting our length of stay and utilization of resources and a variety of other things that maybe could be done better and would be more patient satisfying.

I'm a bit mixed on that, so those are my thoughts.

(Ellen Weber): Yes, I agree with – hear what you're saying that yes, it could certainly, I could see the push back where you haven't fully worked the patient up and –

(Suzanne Stone)-Griffith: Yes, yes, we're do it now.

(Ellen Weber): -- you know, our boarding time is being counted. So, to do it now and then, I'll come down in my orders in the mean time or something like that.

(Suzanne Stone)-Griffith: And we have anecdotal stories, you know, I have a hospitalist just the other day who said, "Now have they had that swallowing study yet." I'm going, "Are you kidding?" You know, that is absolutely not acceptable. But that goes on and we all have countless examples of that. So I do worry about that.

(Mike): This is (Mike). A couple of points. So one, if there is no target for the length of stay, I suppose, it doesn't mean that there's still no measure because right now it's the median time. So there're still being measured. As far as the targets, I can't see the downside but I also note that we have instances where we do have targets. One is thrombolytic therapy within 30 minutes. And the other is on time to put the this in as coronary intervention.

In both those cases we have rather arbitrary targets and over time, people move toward reaching those, so I guess, the question now I have is what's different about those situations than this?

(Ellen Weber): One is I think, first, most of those time targets that are clinical, they're based on some evidence and we don't really have any particular time target that says this is the ideal time to be in the emergency department. I think that was one of the big objections in England.

With that being said, I think you know, we all sort of have an internal clock where we go like – when I started working, if your patient was in the department for more than six hours, you got a letter. You know, what are they doing here? And you know, can you justify them being here?

And then of course, as we've done more workups, and we still think six is a pretty long time and I think most, you know – I would bet sort of there's a group of emergency physicians that could get together on appropriate time frame and they wouldn't be that far apart. Somewhere between six and eight hours maybe, for a person being, you know, that needs a complex workup. So I think it's reasonable.

Male: Yes, I would agree with that and as far as the other things as well. There are clinical factors but thrombolytic therapy is made official a lot further along than 30 minutes. So it's not like these are – these still are somewhat arbitrary.

Female: I don't know whether this (point) come under targets but I want to mention before I forget. But I think we should have something related to psych patients. We really should. I mean, there should be some acknowledgement that the system – the large system does not meet at all the psychiatric care patients that we end up trying to care for.

Male: You mean, they shouldn't be excluded from the measure?

Female: Yes, they shouldn't be excluded and, you know, that's what's usually done. They should not be excluded. We should know exactly what their lengths of stay are and how long it takes us to find a place for them.

(Jesse Pines): That's one thing that we –

(Ellen Weber): We should call that out in all of our – all of our measure sets.

Female: Yes, and we should – yes, and it's not really that we're holding the hospital accountable but we're – but the system at large is failing these patients and people should know that, you know.

(Jesse Pines): Particularly where we're going to be aggregating or plan to aggregate some of these measures to the regional level, particularly the – with the boarding of specific types of patients and actually what Angela and I are talking about here is we're going to have a separate section of the draft report for you to look at for specific populations.

So this has been a great discussion on time target. It doesn't sound like there is – really is universal agreement whether time targets are good or bad. So what we're going to do – it doesn't seem that we can really clearly have a recommendation now. So what we'll do for the draft report is put the major issues in there and then we can discus that more at the in-person meeting and see if as a group we can come up with some sort of an overall recommendation or overall principles related to time targets.

We have basically two other areas to discuss in the last 10 minutes. And I want to make sure that we do hit those and see what people's thoughts are. The first is Measures of Central Tendency. The current measures report the medial time. The median time, as everyone knows is the middle value in a long list of numbers.

And there's been some criticism of that in that if you're measuring a hospital on their average day, that that does not necessary reflect their worse day. You can have hospitals who have a good average day but a horrible worst day and maybe the worst day is a better measure of the hospital's flexibility.

So when it comes to reporting of these measures, we could come up with a recommendation around different types of – particularly in the length of stay measures – how we'd like those reported. And then whether public reporting should include some measure of certainly of average – you know, depending

upon the distribution of the data but also some measure of the variants. So I want to get everybody's thoughts on that.

(Suzanne Stone)-Griffith: I think both are valuable. You know, we measure sort of day in and day out and have, for quite some time, averages. And when you do that you always hear about median and we also report annually some median numbers. But my feeling is probably both are valuable.

(Mike): I would support what you're saying, Jesse, to include those.

(Stephen Pitts): So Jesse, you're talking about reporting both the mean and the variation as opposed to just collecting a median?

(Jesse Pines): Yes, so.

(Stephen Pitts): (inaudible).

(Jesse Pines): Yes, so that's – let's say, you would purport a median length of stay of six hours and you'll report some – like on the high end you'd say, well the 98th percentile, it's 12 hours or 18 hours that you're – you know, in some days, people really have a really extended length of stay. But on the average day, then maybe it's not that long.

Male: Yes, I would definitely agree with that.

(Jesse Pines): Any other comments on that? So it sounds like we got an agreement that we do want to make a recommendation around having some measure of variance in all of these measures.

Female: Yes.

Female: Agree.

(Jesse Pines): OK, now what –

Female: I mean, I think measuring variance is really important. I also think that to me, even more important is doing what you just referred to earlier – measuring the different types of patients. I mean, you know, the patients that go to OR,

patients that go to the ICU, patients that go to the (Cat) labs, things like that. Is there – how much, you know, is that plan – is our charge just to recommend everything we possibly think could work?

Shouldn't we'd be prioritizing? If we can only get five pieces of information on a much larger quality measurement agenda, here's what we want? How are we approaching this?

(Jesse Pines): Well, really it's up to the group, what goes into the report. I mean, I'm thinking about other measures that are used, a lot of those are stratifies by diseases as you know. We could make some recommendation around the, you know, certainly the prevalent diseases or the categories of diseases that we might think in terms of stratified reporting. But that's really up to the group.

Female: I like the median and the 90th percentile or something like that. I don't know if you would want another 10th percentile or maybe just the median and the 90, those would be great.

(Jesse Pines): OK. So in the last few minutes here, essentially I want to do – I want to talk just briefly about structural measures and how we should handle structural measures. And also I want to have at least a couple of minutes – we probably won't have the time for a really robust discussion but think of measurement issues that we didn't think of and certainly if those come to you in the middle of the night, you can always e-mail us and we can include those and explore those with the group.

But – so what we're thinking in terms of structural measure. As we know, there are some different ways of organizing the ED that may – could serve as a structural quality measure for example, the presence of a fast track or the presence of other structural issues like physician to triage or different ways that the ED is organized with regard to the design of internal waiting room.

There's been a lot of new stuff over the last several years on that. Some of those have been associated with differences in flow itself but maybe not outcomes. But I want to open the discussion at least for a couple of minutes and see what you all thought about structural measures of crowding and design.

Female: Interesting.

(Mike): This is (Mike). I guess I would ask to think about them individually. I think to have descriptive factors, I would think maybe more what you're talking about as opposed to calling them structural measures. If they're structural measures then you're saying that in effect those are (good) things and if you don't have them, it's not so good. So I think I'd be – I'm going to look at what you have in mind specifically. But as far as putting that information out in terms of the description of the hospital and it's emergency department, I think that would be fine.

Female: Maybe something like – I mean, I'm just thinking about, you see more ED's now changing over to private rooms and there's less rooms that are shared, like three or four people to a room. Those are like really important in like patient-centered care issues. You know, I know some patients like to listen to what if it's going on with other people. But that's structural – like the physical space and how many rooms are private. It's also a – if in times of a disaster, especially in infectious disease kind of issue, those are important issues, right? How many truly separate rooms you have? Or no.

Male: Yes, you can ask how many negative pressure rooms. I assume that – I mean, I would certainly include the item of whether or not the ER also operates as an observation unit. I think it could make a difference in (inaudible).

Female: Well, I want to just a little bit to confirm – I know we'll have more time to look at the summation. I mean, I feel like we may be moving a little bit away from where there's a robust evidence base especially considering the diversity of emergency departments these measures could apply to. I mean, there are places, you know, is this a single coverage place, I mean, do they say they have a doc in triage, I don't know.

(Ellen Weber): I also was wondering about some kind of cultural measure because I think what you – exactly what you do to speed your throughput is probably less important than whether it's considered a priority by your ED and hospital staff. And I know that would probably require some other kind of survey or something like that.

But, what we've seen sort of in the qualitative literature is that, you know, again, we work at some measured matters but that if people are generally, you know, supportive of it, they do what needs to get done. And it's not so much the individual item that you put into place.

Female: But that needs to go all the way to the top.

(Ellen Weber): Yes, exactly. I mean, it would be all the way to the top. It could be something like, you know – and when they have the target in England, if you would hear this qualitatively then nurses on the floor would say or your nurse in the department, "Well that's your target, not mine." And there was not a sense of some places that this was a shared goal. And, you know, or, you know, is quality a shared goal or something like that.

But there's been, you know, fair amount of literature suggesting that these kinds of improvement occur best with the best outcomes and the least gaming. If there's actually a culture that supports it and says this is the right thing to do as opposed to the joint commission is asking us to do this.

Female: Right.

(Ellen Weber): So I don't know if it –

(Jesse Pines): So everyone, actually we're sort of nearing our endpoint here. This is a great discussion. And I wish we could continue for another few minutes here. But unfortunately we sort of have to move on to some of the other logistic steps that we've got to do specifically the public and member comment.

I'm going to go ahead. I just want to thank everyone for all their attention and great comments on the call. We will be integrating that in to the report and sending a draft report out soon so you can review before the in-person meeting. But I'm going to go ahead and hand it over to Adeela. Go ahead.

(Adeela Khan): (Natalie), can we open the lines for public and then we'll?

Operator: At this time, if you would like to ask a question, please press star then the number one on your telephone keypad.

Again, that's star one.

At this time you have no question.

(Adeela Khan): OK. I guess we can move on to the next step. So our in-person meeting is scheduled for October 17. It will be from 9 to percent. You should've received a logistics memo with travel information. And so we ask that you RSVP and book your travel as soon as possible.

After this workgroup call, we're actually going to be getting transcripts from the call and we'll be writing up our workgroup summary to send out to you. Just a bit of a summary of what was discussed today and we'll also be integrating that into our draft report.

If you have anything else, feel free to e-mail me and any ideas that maybe we didn't cover today. Jesse, did you want to add anything else?

(Jesse Pines): No, no, no. I just wanted to again thank everyone for their attention and so there were a number of really great comments about additional sections we want to add in. If there's any sort of big, broad areas that we missed or things that you think of later, please let us know.

(Adeela Khan): All right. Thank you everyone for calling in. And we'll see you on the 17th. OK, bye.

Female: Bye.

Female: Thank you.

Female: Bye.

Operator: This concludes today's conference call. You may now disconnect.

END