National Quality Forum

Moderator: Sheila Crawford
September 28, 2012
4:00 p.m. ET

Operator: Welcome to the conference. Please note today's call is being recorded. Please standby.

Angele Franklin: Hello. This is Angela Franklin, and welcome to the Regionalized Emergency Medical Care Services Project. Today's call is focused on Workgroup A and the topic is Emergency Preparedness, and I want to introduce myself. I'm the senior director for the project and with me Adeela Khan who's our project analyst, and we also have on the line Dr. Jesse Pines, and Jesse did you want to tell us real quick a bit about yourself?

Jesse Pines: Sure, I think, I actually know many of you. Jesse Pines, I'm (inaudible), and I'm a faculty at George Washington University, and in part, also direct the Center for Healthcare Quality, and I am the consultant on this project on behalf of NQF.

Angela Franklin: Thanks. So, I think – next, we'll go ahead and do a roll call of the folks on the call, and as you're announcing yourself, could you just tell us just a little brief – a brief background information about yourself.

So, Adeela?

Adeela Khan: Do we have Brent Asplin?

Emily Carrier?

Brendan Carr?

William Fields?

Edward Gabriel?

Rebecca Katz?

Rebecca Katz: Yes. Sorry, Adeela. Do you need us to say about – say anything at this point?

Adeela Khan: Oh, sure, you can just say a little bit about yourself.

Rebecca Katz: All right. I realized that nobody else is speaking first. I'm a subject professor at George Washington University in health policy, working on emergency preparedness and disease surveillance.

Adeela Khan: OK, David Levine?

David Levine: Yes, I'm here. I am vice president of Informatics and medical director at UHC which is a member organization with Academic Medical Centers across the United States. I'm an emergency medicine physician, and prior to UHC, I was the medical director of Cook County's Stronger Emergency Department for a number of years.

Adeela Khan: OK, great! Thank you. Anthony McIntyre?

David Marcozzi?

Gregg Margolis?

Linda McCaig?

Melissa McCarthy?

And Ryan Mutter?

Ryan Mutter: Hello, this is Ryan Mutter. Happy Friday to all of you. I'm at the Agency for Healthcare Research and Quality where I – I'm the coordinator for Emergency Department Research Activities and Data Development.

Adeela Khan: Thanks. AnnMarie Papa?

AnnMarie Papa: I'm here. I'm the clinical director of the Emergency Department at the Hospital University of Pennsylvania at the Nursing Department, and have had experience in the Emergency Department for over 35 years, but I started at age 10 just so you know.

Adeela Khan: OK. Sally Philips?

Stephen Pitts?

Jeremiah Schuur?

Jeremiah Schuur: Here. I'm an emergency physician in Boston in Brigham and Women's Hospital where I direct quality for the E.D., and I'm also the chair of the Quality and Performance Committee for the American College of Emergency Physicians.

Adeela Khan: Thank you. Manish Shah?

Manish Shah: Hi. I am emergency physician at the University of Rochester in New York and also the associate chair for Research in EMS Division Chief. I also serve as one of the county's EMS medical directors/

Adeela Khan: OK, thank you. Suzanne Stone-Griffith?

Michael Rapp?

Kathy Robinson?

Arjun Venkatesh?

Arjun Venkatesh: Hi. I'm an emergency physician, as well as Robert Wood Johnson Foundation clinical scholar at Yale University and I – last year did a mini-fellowship at NQF and participated in the previous day of this project and also served on the ACEP Quality and Performance Committee.

Adeela Khan: Ellen Weber? OK, I think that's all.

(Kathy) can you make sure…

Operator: Yes.

Adeela Khan: … all the speakers have their line opened please.

David Marcozzi: Hey, I'm sorry. It's Dave Marcozzi. I was on mute and I had an eloquent introduction but I talk only to myself.

Adeela Khan: You can go ahead.

David Marcozzi: Just calling in from ASPR/HHS. Thanks.

Adeela Khan: OK. Thank you.

Brent Asplin: Brent is here.

Adeela Khan: I'm sorry, did we hear Brent?

Brent Asplin: Yes, Brent Asplin joined. President of Fairview Medical Group in the Twin Cities, and outgoing chair of the Quality Performance Committee for ACEP.

Adeela Khan: OK, thank you very much.

Brendan Carr: One more add in there. It's Brendan Carr. I'm Emergency Division Policy researcher at the University of Pennsylvania and I work part time at ASPR with Gregg Margolis in his office.

Adeela Khan: OK, anyone else that I missed? OK, we'll turn it back over to Jesse and Angela.

Angela Franklin: OK.

Jesse Pines: OK. (Inaudible). So, essentially we've got the next almost two hours slated for t his. We're going to be doing number of things essentially first I'm going to – we're going to talk a little bit about sort of an overview of the project and what our goals are and then we're going to go into the details, a little bit about

what's happened on the call yesterday, and there was the first workgroup call on crowding happened yesterday.

Today's call is going to focus on preparedness and also we're going to have I think a detailed discussion about daily surge and daily crowding and disaster surge. So, essentially the – sort of 50,000 (inaudible) is that we are creating a document on behalf of NQF that will hopefully detailed measurements concepts and issues related to E.D. crowding and boarding and emergency preparedness at the level of the hospital for healthcare facility.

So, essentially, and I wanted to essentially talk a little bit about – this is purely about (more) health system preparedness then necessarily public health preparedness which I think helps us in preparedness is really a subset of that and finally we are going to talk about a little bit about accountability and regionalization and pretty much to explain on that is that – is that when we started thinking about measurement in all of these areas, that we can potentially aggregate measures not only at the level of the hospital or health system but also that they may – can be potentially aggregated to the level of the region or community.

So, it might be of hospitals or health systems the incentive to collaborate for the combined goal of producing system crowding and also including improving preparedness at their individual facility.

So to go through sort of a detailed look at what the overall report is going to look like, the – essentially you'll notice the document draft report summary which sort of gives you the frame of what the report would like. You also should have a number of other documents including the environmental scan which was done back in April of this year that was done by NQF and listed several of the current crowding measures and boarding measures out there in the preparedness measures that are out there.

In the preparedness world, I know over the last year, since April, there's been a lot of work in this area, done by a lot of – a number of the folks on this call related to a lot of the work credit a number of people have done specifically

Dave Marcozzi and the measures for the Hospital Preparedness Program, the next one health security index and other projects.

So, the current environmental scan because it was done just a few months ago. I think it's by definition going to be out of date. So, our goal is really to sort of update that as part of this with a number of the current initiatives that are going on now.

And so, I'll only talk a little bit about what happened yesterday. So, yesterday, we talked about issues with the E.D. boarding and crowding and are we decided on use Brent's model the input, throughput and output model as a frame for scoring different ways to measure crowding and boarding. There were some – there were some discussions of whether or not we just want to focus on throughput or whether or not we actually want to start thinking about input and output types of measures specifically looking at access of primary care and other issues that actually may cause Emergency Department crowding, and also looking into the end potentially transfers.

We also looked at a number of different measurement issues that are really unique to crowding including issues of the different data sources. There might be available paper or on (chronic) base record. We had a discussion on the definition of crowding terms and there have been two major reports on that in the last several years that has sort of created a (lexicon) for crowding. Really the major unanswered question now is still the definition of boarding and when boarding starts. We had a very nice discussion there.

We also had a discussion about risk adjustment and some of the pros and cons of requiring a risk adjustment as or suggesting risk adjustment as a part of – a part of crowding measurement specifically because some factors exogenous to a hospital might – been (soon) to be associated with the performance in general. Bigger hospitals in cities tend to perform worse on these measures than smaller rural hospitals and also their pretty (traumatic) effects based on case mix and other factors out of the hospital control.

We also had some discussion about time target and we had Ellen Weber on the call yesterday. She's done a lot of work in the U.K. looking at their (four-

hour) rule and we – and part of the – part of this report going to be some recommendations about individuals on targets and whether or not that would be would or would not be desirable for reporting performance measures for crowding.

We talked a little bit about measures of central tendency whether or not we should repeat reporting just median data that was – that were included in the 2008 approved measures. The group decided that we wanted to – we should probably be reporting some measure of variance and as a group agreed that 98 percentile was – as an appropriate level for variance reporting especially when it comes to length of stay measures. We also talked a little bit about structural measures and – of crowding and specifically looking at structural elements that an Emergency Department and as potential performance measures, a quality for example the presence of a fast track or an observation unit or other sort of individual intervention such as – such as physician in triage.

Excuse me. Sorry about – I'm in home here and the dogs are barking. I believe that's not too distracting. The – now, I'm just going to get into some of the overall goals of the project here in the context of sort of the next phase of this project which will be to develop performance measures, hopefully, in a two- to three-year consensus development process that would occur some time in the future. That process has not yet been funded but our goal would really be to sort of set the runway up for national – for that consensus development process specifically looking at all the different measurement issues or detailing measurement issues in crowding, boarding and preparedness coming up these series of recommendations for measure developers and also really making recommendations for measure developers in terms of, you know, what, you know, what sort of things should they consider when making these measures, and specifically putting in the frame of preparedness.

There are – it's sort of a unique area in a way because a lot of times you're measuring things that haven't happened yet, you're measuring things like the capacity to respond to a disaster and how does that fit into the NQF framework per performance measurement and part of this is going to be creating a document that really sort of modifies the NQF standards for performance measures for preparedness measures as a work product of this

group. I do want to clarify our goal is not to lower the bar at all but really – but rather sort of modify what we think might deal into preparedness measures given the limitations of the data and the evidence behind them.

So with that, I wanted to open up to any questions about their overall goals, and what's going on so far.

Brent Asplin: Jesse, this is Brent. I don't – the memo I had had the boarding and diversion call this afternoon and the preparedness call yesterday. That was the original memo. So, I'm not sure why is that – when they got switched, but I apologize for that. I'm probably going to drop off the call here.

Jesse Pines: Well, actually Brent. I think – I think having, you know, the real benefit of having crowding people and preparedness people on the same call specifically having crowding people think about preparedness in general. One of the main goals of this is to bring this world together conceptually and also practically when it comes to performance measurement.

So, you know, I mean I think that, you know, particularly when we have a discussion about daily surge and preparedness and sort of what that – what that means, I think your input would be really helpful.

Brent Asplin: OK, I'll (help) you some as I can. Thanks, Jesse.

Jesse Pines: OK. Is there any other question before we get into the discussion of preparedness?

OK. So, essentially what I wanted to do is to talk a little bit about some of the specific issues in emergency preparedness. On the call, we have people like Brent and (Jay) and – who are maybe more – a little more familiar with the crowding world. We also have several really focused preparedness people on the call.

So, essentially the first part of this report is going to be a – sort of a recap of the current measures for emergency preparedness. We're also going to be updating our environmental scan to include some of the more recent developments of performance measures from the – from the hospital

preparedness program, the national health security index and any other processes related to developing performance measure preparedness that you all – or know of that are going on right now.

So, I want to stop there and see, you know, there are several measures out for preparedness for health system preparedness that have been proposed and are in the process of being developed now. Are we missing any big areas there? Maybe Dave Marcozzi could just let us know that, you know, that we've got some of the information from the national health security index. We have some information about – some of the public information about the hospital preparedness program.

Do you all know of any other sources that we should have for or sort of – for us to prepare these measures?

David Marcozzi: Yes, I'll start obviously. There's a lot of expertise on the call. So, what we're talking was this – I mean, the first thing that (a lot of) the optic, we have to make sure that the hospital preparedness program is to be understood on these calls. We're coming out from a coalition basis. And the reason why that is for – well, there's multiple reasons for that but first and primary reason was that hospitals don't act in isolation after multiple events and certainly a lot of literature out there engaging other hospital or health care institutions, other long-term care facilities, primary care to actually execute the ability to respond to an event has been found to be most beneficial. So, that was one of the (pivots) this year from a hospital-based grand program to more of a coalition of community based and help community-based standpoint.

As for the second would be shift from where we were previously and really measuring capacity and thinking about capacity to a shift toward capabilities. It was a (inaudible) who directed it that spoke to this back in I think March of 2011 and to that end both the public health community and the health care community and then around emergency preparedness have a standard core set of capabilities that we all work towards for that all those coalitions are working towards in some of those capabilities for instance are information sharing or volunteer management or medical surge.

Each of them dovetailing off of that each of those capabilities then has specific and targeted performance measures. Traditionally, we have seen that the – what we measured are hospitals and health care systems against where the ability to plan, and at times, we would – we would exercise but we realized that the hospital preparedness program looked to – I don't know historically looked really to only put emphasis on the ability for coordinated planning, and the big shift this year is the – is in and around that with the ability to plan, but the ability to execute those plans (doing) drills, exercise for real world events.

To that end, I'll speak to one of the performance measures, and this is just one and then I'll stop here and (sort of go to) everybody else. One of the major shifts this year is in and around the performance measure for medical surge, and I would encourage all of us on the phone to at least take a look at it. It's really stemming from some of the work that gave (inaudible) in 2006 and reverse triage some of the international work and also is coalition base and that is the ability for a coalition to be able to – concept is immediate bed availability, IBA.

The ability to offload 20 percent of your coalition's bed higher – lower acuity bed patient to accept higher acuity patients to those – to those beds and that's the concept of medical surge with no new staff, stuff or space, and it's really allowing the individual-based health care system that we have today to shift to a population-based system and the trigger for that are the bright line and the (sand) would be an externally declared disaster.

So, someone outside of busy E.R. doctors on shift and saying, "Gee, I got 20 belly pains versus 10 belly pains yesterday." That's different then and external entity and government official or other saying that we have a declared disaster for this area and that allows that shift. I think there are some consistencies with the course of (inaudible) of care that the IOM stood on from a conventional to contingency. This is more of a contingency shift to delivery of care and also build into the construct that disaster preparedness and medical – and quote "medical surge" may not be as fruitful to think about and discuss as building in to the daily delivery of system of the care that we provide today and irrespective of the hospital preparedness programs $350

million program if in five years now that goes away. If we're successful, then the concept of IBA last – but far out last the appropriations of the – to the hospital preparedness program.

So, I'll stop there. If there's a lot more I could talk about and I'll just only say that the (inaudible) of medicine upcoming in the end of October are we talking about the concept of IBA further but I look forward to working with you all to see how we could maybe bring that concept into the applications we're speaking today.

Jesse Pines: Thank you very much Dave for clarifying that. Any – maybe this is a good time then before we sort of getting to the measurement issues while we still have some of the crowding folks on the call to have a discussion about daily surge versus, you know, daily crowding versus emergency preparedness and sort of hear from – hear from both sides. How, you know, we have the, you know, the various ways of measuring crowding – daily crowding mostly have to do with issues of length of stay, waiting times, boarding times, (left) of not being seen. There are other sort of static waves by occupancy rates and that sort of thing.

On the preparedness side, it – and Dave, you alluded that it comes down to sort of your – the capabilities sort of the stuff that you have and then your – I'm sorry, your capacity which is the stuff that you have, so sort of counts of supplies and equipment and your capacity which is your – I'm sorry, your capability which is your ability to actually use that in a disaster and that can be assessment in a number of ways for example, you lose these drills and exercises in actual events. It was, you know, differentiate the two is crowding is more of a daily thing, you know, you might have be crowded by about seven days a week, but your disaster may happen once a year or less, and the really big disaster hopefully happen much less than that.

So, I just wanted open it up to see what folks thought about how we can, you know, reconcile this two measurement areas.

(inaudible)

Male: And doing those bigger ones.

David Marcozzi: Yes, Marcozzi here. I'm afraid to pause. I'll jump in since – I'll take the first hit, the swipe of this. So, I mean we're having the discussion right now. I'm trying to define what the stress to hospital system looks like (device) where the tipping point is on the – on declaring a disaster and where that – if there is one where that line is – and is it a – is it a mathematical model, you know, certainly, what (Gab) presented previously or is it something other than? Is it a shortage of supplies? Are there – are there economic issues associated with this.

So, I'll let you know that we are grappling with a lot of the same things here at HHS. I'm trying to define where busy doesn't actually equal disaster and what's the difference between the two, and a lot of different ways to (skin that onion).

Male: Thanks, and it would seem to me that if you have a place that is sort of chronically crowded and a sort of adapted to that, you know, that may suggest that that place may be potentially, you know, either more or less able to handle patients and disaster. One of the things that was mentioned on the call yesterday was you've got certain hospitals that have a lot of boarding hours, have sort of adapted to that and, you know, maybe – be able to, you know, may be able to increase that, you know, even higher in the event of a disaster where there's a place that doesn't have a lot of boarding hours, may have sort of less flexibility in their system.

You know, I think alternatively, you could have a place that is just the processes are – the baseline processes are so bad that even if you have a disaster on top of that that it's just going to overwhelm the system much earlier than, you know, that a place that is more efficient at baseline.

Brent Asplin: Jesse, this is Brent. Can you hear me?

Jesse Pines: Yes. Mm-hmm.

Brent Asplin: Hey, sorry. I mean, I think part of the – part of the challenge here is nomenclature because I think the word disaster just has such a wide range of definitions in some respects. I think when you look at the truly significant

national media type event disasters. The level of overlap between the – both measurement and operational issues that we talked about from a daily boarding capacity, operational efficiency perspective and the types of measures or assessments or operating platforms you would try to deploy on those true large scale events. There's pretty – I don't there's a lot of overlap, but as you mentioned, hopefully and thankfully those are relatively uncommon events particularly in any given region.

On the other hand when you really – one of the other challenges we have, I don't think we do a very good job in the daily capacity and crowding area to expand our capabilities and capacity commensurate with the demand that's being placed on the system. We just make people wait longer rather than queue up resources to respond and keep our performance parameters with the (uncertain) limits. We just let our performance deteriorate. I think it has a lot of – we do that largely for economic reasons I believe frankly. If were to do that, I think that the level of overlap between our scale (above) day-to-day resources and quote/unquote, "small scale disasters" would be quite high and we would use a lot of the same terminology because the tactics we would deploy and the measurement systems we have to deploy on a day-to-day basis to increase our capacity in response to surge that's in demand and the tools, measures and tactics we would deploy to respond to small scale disasters I think would largely be the same.

So, I think that's – as we have nomenclature problems and the word disaster to me is isn't really meaningful other than the obvious, you know, we can obviously name disasters from the recent history and past history; but otherwise, we really need to kind of define what the low levels of quote/unquote, "disaster" mean and how that overlap interacts with daily surge.

Those are my thoughts. I haven't spent a lot of time in the space thinking about it lately but that's part of the delay, but I think that's part of our challenge.

Jesse Pines: Great! So, Dave, I don't know if you all have had these discussion about sort of thinking of disaster of lesser sort of a binary phenomenon as or more in

categories, sort of scaled categories in any of your working in E.D. and you've got a bus crashes outside, and you've got you know, 10 new patients to take care of. It's, you know, I guess it's a disaster. You've got multiple trauma alerts at ones. You could also call that a disaster where as, you know, obviously you got, you know, the (Derecho) and the Hurricane Katrina and, you know, that are – that everyone would agree on our disasters.

I mean, how do you or how do, you know, want to hear from of the – also the preparedness? How do you all reconcile this sort of nomenclature of – what is a disaster? When does incident becomes an incident or is there any sort of gray area there?

David Marcozzi: I mean, this is, you know, we even talk – there's a lot of discussion on this one Jesse. There is not – there is not – certainly not black/white that all of a sudden we're in it, and I mean, and sometimes I guess you can get to that point, and I – we all know everyone on this phone knows that this is no a hard and fast, but you know, the optic that I bring to that as of – I'm not sure what had – you'd like me to provide input, too on this call, but as the fed, we have to think about it from a perspective of other – they certainly are defined the triggers that we think about when we declare disaster, you know.

It's a public health emergency declared and what are the triggers. Has FEMA declared a (inaudible), and there are FEMA triggers to allow that to occur but that said, you're talking about, you know, when we kind of all know that there is disaster advice, what I think you just described for a bus accident for, you know, hospital and E.R. with five patients or, you know, a bed capacity of five beds that's a disaster. So, there's a – there is gray if that's a short way to answer your question Jesse. I mean, it's stepwise and tiered, but yes certainly it is gray.

Jesse Pines: But, you know, I think that…

Male: This is…

Jesse Pines: … you know, maybe one of the things that this group could do is take some of the first steps in sort of defining what those areas are, and you mentioned Dave some, you know, clear sort of triggers that might be – they could define it in

terms of external triggers but is there any other way to quantitatively that we could think about, you know, what, you know, what exactly is an incident – who can really sort of pull that trigger and is there any way to sort of quantify, you know, once, you know, once you've got into the point of being a public health emergency or also you kind of thinking about it from the hospital's perspective a, you know, a disaster for that hospital might be an overwhelmed Emergency Department or maybe, you know, specific of them what's in, you know, what, you know, what's in the hospital like the, you know, the shooting happening at Hopkins where the – where the doctor got shot up on the floor.

I mean, you know, is that a disaster or what, you know, what, you know, what sort of qualifies because the, you know, the countermeasures – the expected countermeasures that would mitigate some of the impact the disaster may be different and they vary by disaster or should certainly vary by disaster, you know, from the serious stuff to this really minor stuff. So, try, you know, over the last, you know, few weeks I though I've been trying to lead through the preparedness literature to try to – to try to understand where the – how the preparedness world falls on this.

But essentially sort of moving preparedness into NQF standards, we need to have very, very clear explicit definitions of, you know, what is a disaster and when would a specific quality measure apply to that disasters particularly when it comes to the capabilities because if you're going to measure how a system responded to a disaster, you want to know sort of when, you know, when that – that's triggered.

Brendan Carr: Can I jump on what you say. This is Brendan. You know, it's interesting to hear and then to hear Dave and Brent talking in (tandem). I actually I think (Brent) said pretty nicely. I mean Brent knows that we know what happens – what happens when the demand overwhelmed the resources is that we just let quality suffer. And David saying I think the same thing which I that well we sort of, you know, I know it when I see it when I can't keep my head above water, might use the word disaster. We might sort of pushback from that word and let that be maintained as a (staff or doctor) and some sort of official designation and create a new language here. But to hear you guys say that

same thing, makes me think, well, you know, if we sort of to have sense that all this suffers when our resources are overwhelmed.

I think the NQF has rolled in and to help us to articulate what quality means in this realms so that in these (delays) so that we can then know when it is suffering because you know, then, and then those metrics, right, whether I think – if that's a (task) to identify those metrics, and we can look at them at the level of the hospital but you can also look at them at the level of the (Marco's) subject coalitions or whatever the word reasoning and start to sort of something is up, and say, "Wow, this region is not overwhelmed. Three of the eight hospitals in this regional are overwhelmed." And then the question becomes one that Brent touched on as well which is – and the reason they're overwhelmed is to say the (best friend) recognition, and people choose to go to them even though they're getting a lower quality product.

So, then it becomes a very complex question about how you then sort of, you know, when I said – when I said, "true disaster" or T.D. but, you know, people on the bus and take them to a different facility or you tell, you know, the ambulance crews that this place is closed, and you're taken to this place instead. When its market forces, it's a much quicker thing, having 15 or 20 people sitting in my waiting room, they don't – they would rather sit there for a couple of hours then head down the road to a different place because of – because of the (branding).

But anyway, I mean, I do think there is good synergy here, and I think the topic is fascinating, and I hope that we can find the right language to allow us to sort of, you know, get this moving forward.

Brendan Carr: Jesse, Brendan. May I add one other concept here which is I think we are probably comfortable as a group. I won't speak for the group but having had lots of conversations with many of the people on this call about these topics, we may be comfortable bridging from measures of capacity, measures of throughput and therefore delay and measures of boarding as quality measures since many of us, Jesse certainly in particular and others, there've been a lot of work pointing out the associations between gaps in care and increasing like morbidity or outcome with these delays.

But it was very interesting experience talking with kind of the other side of NQF or with measures application partnership just over the past few weeks when the throughput time measures were actually not included in the MAP's recommendations of families of measures to be used for measures of care coordination and quality and safety. And that I don't want to overstate that. I just think that's another (length) that we need to keep in mind because other parts of the health care and other policymakers often see these as measures of efficiency and not necessarily quality.

So, we have to kind of also continue thinking that (length) and perhaps including some other components of this other than simply capacity and in terms of surge and demand versus available capacity of the (length) between the two but also try to continue to think from a patient outcome perspective.

Jesse Pines: Well, you know, I think – I think it really is – it really has lengthened and I think – and I really appreciate this discussion sort of formalizing some of the things in my mind and essentially Dave when you talk about crisis standards of care during a disaster that is – in the crowding, saying that is, you know, crowding care suffering during more crowded times, and really, you know, I mean I think that sort of aligning that those definition of terms in terms of what we're talking about and we're trying to achieve.

I mean – I mean, essentially, we want when a disaster happens on a – on a large scale basis, we want people to get the same quality care that they would get on any – on any other day. We don't want them to wait longer or not have the availability the same resources or have to, you know, to truly prioritize – to try – prioritize patients either who are really, really sick. We want everyone to get the same care, and I think on a daily basis, you know, same thing, we want the Emergency Care System to deliver the same quality care on a, you know, on a 5 o'clock on a Monday afternoon when we're boarding half E.D. is full of inpatients and the waiting room is packed.

You know, I mean, essentially at the same concept, so maybe a (piece) of this is sort of trying to standardize the nomenclature between the two groups and,

you know, and also sort of, you know, frame it in the same way. Am I getting that? Am I getting that right?

David Marcozzi: Jesse, (Marco). So, you're saying that – I mean, I won't – I won't disagree with having common nomenclature of which we stand on and can move forward out on. So, I think that's a decent idea, and a good for staff.

Jesse Pines: Great! So, this has been a really – a really good discussion. Other thoughts on – I mean, sort of went backwards that was one of the – that we're going to discuss daily crowding and disaster surge later on in the call but I think we've had a good discussion there. Any other thoughts on reconciling daily crowding and disaster surge?

Brendan Carr: This is Brendan. You know, I apologize if I'm too such (inaudible) to the crowd, but I am unaware of a conversation that Brent was talking about how – I thought – I thought some of the throughput metrics were going to become or we're on the way and now you're saying that they have been – they have been held up?

Male: (Just) – there's still approved measures by NQF. They've been into the – since its development process and they are in CMS programs today. So, they are still there, and CMS still can choose to continue using them but measures applications partnership was – is due to NQF's report to CMS and perhaps I think, (Jesse) can you even clarify further than this but they will be recommending.

One of their goals was look at all the measures that have been approved in various categories, to try to call the list and provide focus and make recommendations to the CMS about which of the measures are most important in the various categories and families of measures for CMS to consider and others to consider for a value-case purchasing and other payment programs.

So, sorry if I'm confusing, this is relatively reason and the Quality Performance Committee has been going back and forth a little bit with MAP at NQF which is sort of one of the other side of the (shop) but the measures still are approved measures and CMS still has them outlined…

Male: Yes.

Male: … in the same as…

Male: The power is going to be as (I just never) said, they are not as important other thinks.

Female: We could...

Male: That's correct. At this point – in this particular category and part of it was you have to create categories, and it wasn't the ideal fit for the category that's part of the reason. It doesn't mean that they thought it was a bad measure per se. It's just interesting that their take on it was that there were more efficiency measures than quality measures, and I think this group I would say would be safe to say would come to a different conclusion.

Male: (Brendan), thank you.

Angela Franklin: Brent, this is Angela. We'll certainly follow-up with them to see if we can, you know, incorporate what we're doing with what they are doing and make sure that we're kind of making sure they understand the issues that we're working with on the side.

Brent Asplin: Yes, we had a good call. I'm doing a Friday afternoon calls with NQF, it seems like…

Angela Franklin: Oh, well. OK.

Brent Asplin: Last Friday, we had really good discussion and with Tom Valuck and others about that. So…

Angela Franklin: OK.

Brent Asplin: … but that would be great. Thank you, Angela.

Angela Franklin: Sure.

Jesse Pines: That's – yes, that's very helpful. Yes, just to, again, clarify the MAP can make the recommendations but still CMS can decide to put – they can make their independent decision about what they want in value-based purchasing program or other programs. And so it's only really a recommendation.

OK, so next, I wanted to get people's input on some other parts of the report. The conceptual framework hat we chose for this is what's called "the common ground framework," and you can see that in the report itself. The common ground framework basically looks at the different steps during a disaster specifically preparing, managing, monitoring, investigating, intervening and recovering are the steps from the pre-incident to the incident to post-incident.

Really, our goal is having a work for the measurement is that we could take the current measures and put those in to those buckets and to see what sort of a (hole) there might be in performance measurement in this area. The result of that yesterday, again, was to realize that, you know, (gee-whiz), we pretty much only have throughput measures and maybe some output measures for – when it comes to crowding, but I'm not sure how familiar people are with the common ground framework. It is currently in the draft report so you can see that in figure 2, but I wanted to open it up. I know that especially some of the preparedness folks have thought a little bit about these different frameworks and see if we're on the right track or should we consider other frameworks.

Also, another good frame is the comparison of several different frameworks – the National Health Security Strategy, the National Response Plan, the CDC's Public Health Emergency Preparedness capabilities. You know, I've also been sort of mentioning that as possibilities. So, I don't know if Dave or other preparedness folks if you could comment on, you know, is the common ground the right framework what we did hear from Anthony McIntyre who was on the call yesterday that he agreed that – there was kind of the big buckets for preparedness measures but when I opened up to any thoughts on the conceptual framework or others that we could consider.

(Audio gap)

David Marcozzi: I seem to be on hot seat with this one Jesse; it's Marcozzi. (Margo) is he on?

I don't know if Gregg and I had a chance to discuss the framework. Gregg, are you on?

But…

Male: I think – (Marco), I'll take him for you. I don't know where he is. That's surprising.

David Marcozzi: Got you. Yes, the only reason I'm pausing, I just wanted to – I haven't had a chance to kind of give it due diligence Jesse yet to provide really a good content nor if I had a chance with being Gregg on his in my thoughts on this before to engage. So, I'll pause and I probably – I probably need a little more time to be able to review it.

Male: OK, yes. There's no problem.

Angela Franklin: (Kathy), can we just check and see if there's – if Gregg Margolis has dialed in and if his line is open?

Operator: Yes, ma'am. He had dialed. His line is open now.

Angela Franklin: Oh.

Gregg Margolis: Is it open now?

Angela Franklin: Yes, it is.

Gregg Margolis: Oh, OK. I've been kind of chime in.

Male: All right.

Female: Sure.

Gregg Margolis: No, problem. On that, I need a chance to review this a little bit more as those Dr. Marcozzi. So, thanks for passing it along and I'll get feedback as soon as possible.

Jesse Pines: Great! Any other thoughts on the conceptual framework. So, from the other folks I don't know – I don't know if other had a chance to sort of take a look

at figure 2. You know, this was based on our pre-work. This is the one that we had thought was best, but if people have other opinions, we'd love to hear it or, you know, Dave or Gregg if you want, just let us know offline it's also fine.

OK, then we'll go ahead and move on. Our next section is about the – I think we've touched on this some, but the definition of preparedness itself and there have been several different definitions that have been proposed for sort of what preparedness means. Probably, the most sort of agreed upon is the Nelson definition and I'll just go ahead and read that for those folks who don't have – open and this – and also just to – just to clarify the – we're really talking about health system preparedness here.

A lot of these definitions of general preparedness really have to do with public health preparedness and essentially we're sort of adapting some of those definitions to deal with – to deal with health system preparedness. So, essentially the definition here is the emergency preparedness as the Nelson definition it says, "It's the capability of the public health and health care systems, communities and individuals to prevent, protect against and quickly respond to and recover from public – from health emergencies particularly whose scale timing are unpredictably threatens to overwhelm routine capabilities."

That is the definition that we sort of chose as the – our leading contender for what – for this project. If there are other thoughts of different definitions and there are – there are many out in the literature. We're certainly open to that and also one of the things that we could – we could potentially do is try to – try to bring together, you know, maybe have a glossary of terms in the report that could define several of the terms for crowding and boarding, you know, including about, you know what we think about what preparedness is in general.

So that will be certainly added to the report, but I wanted to open up to any thoughts about sort of the definition preparedness and also to kind of think – to mention the NQF recently did another panel on population health and, you know, if population health and preparedness are similar in the sense that both

are very tough to measure and really sort of rely on different measurement concepts than sort of standard performance measures such as, you know, taking the patients with MI seeing (inaudible) to the (Catlab) quickly or other, you know, we're looking at things like death or other things that they are more easily observable in claims data.

The thing that's tough about preparedness measurement is that a lot of the data does not come from standard sources. A lot of the data does rely on surveys, table top exercises and when you – when you have – when something a disaster happens or what we call "as disaster or incident happens," we don't necessarily have what was called "the counterfactual" which you don't really know what had happened, had you not been as prepared as you were.

So, just by definition, you don't really have a control group of what a lessor or (rate) of response necessarily would have looked like. You also have issues of – the disasters are very different from bioterrorism to weather emergencies to the different types of condition-related issues that might come up, for example, comparing H1N1 to H5N1 to SARS.

All of those were very different – are very different epidemic characterize by differences in volume, severity of patients, the hospital resources that we're required to take care of them and also (thinking) to Katrina, one of the – one of the major issues with Katrina was time. Certainly, that lasted several weeks whereas looking at the (Derecho) which was the major storm that hit D.C., you know, that was sort of a one-time event and then you had to recover from it.

So, anyway, I wanted to open it up to any thoughts on sort of how we go about defining this glossary. Do we want to come up with and agree on it a definition of what we even mean by preparedness, and how do we – how do we best agree on that?

Brendan Carr: Jesse, this is Brendan. Can you (say) what document you're working of for the definition? I went back and I – I'm finding the definition for the framework…

Jesse Pines: Sure…

Brendan Carr: … but for the framework, but I couldn't find the definition for preparedness.

Jesse Pines: Yes, this has been the sort of the longer draft report. It's I think 09-26-12. It should've been in the documents that were sent and it's entitled, the heading, "Defining Preparedness."

And there are you know, just to mention for those who don't have it opened there, there was a systematic review that was done back in 2005 that at best, 27 different instruments of measurements of public health preparedness but there was, you know, there was basically very, very different definitions of what each, you know, each of the instruments defined as what is being prepared.

Female: So, I'll just put it up on the webinar for those of you who are on the webinar.

Male: My apologies. I didn't mean to derail you there.

Jesse Pines: OK. So, maybe for some of the preparedness folks, I mean, what, you know, you all have been sort of more involved in these discussions around definitions. Do you all feel that there is a consistent standard definition that we could use for this project beyond the Nelson 1 or sort of adapting the Nelson 1 for this document or is that necessary? You know, what have been the, you know, some of the discussion that have gone on around that.

Gregg Margolis: This is Gregg Margolis. I think we need to laser in on the definition of preparedness to limited to healthcare system preparedness.

Jesse Pines: OK. Yes. So, essentially I agree and we will – we'll plan on adapting the Nelson definition to reduce the scope to help us in preparedness.

Gregg Margolis: Then I think we need a conversation about what do we mean by health system and does that include hospitals, nursing homes, dialysis centers, EMS, et cetera, primary care, emergency departments but I do think we definitely need to narrow this definition, the health system and that a serious conversation about what we mean by health system. And I think some of the HPP documents that have recently come out will help out in those areas.

Jesse Pines: OK. And there's also the HPP documents that are online or are there any additional documents that you could share any sort of – other documents they might have to help us define this better.

Gregg Margolis: David Marcozzi and I will talk and give you some information. But on specific or referring to some of the guidance that talks about what kind of entity should be in healthcare coalitions.

David Marcozzi: Yes, Gregg. It's Marcozzi. Jesse did the – we'll ship you over two documents. The first is the capabilities. Yes, they are aligned and both documents actually are aligned. The second is recently posted is that area around performance measures and the way the hospital preparedness program I thinking about defining what preparedness is.

I mean from (where the house) of preparedness program sits, you know, I draw two points. First is that the hospital preparedness program stands in its capabilities. The capabilities are analogate to a football game. You have a good offense and a good defense, and a good special team. But the truth of the matter is, the ability to score a touchdown, you're not going to win the game even if you have a great offense or a great defense. You need to kind of have everything. And in the performance measure is that touchdown is the deliverable at the end of the day.

So, the capabilities are those offense or defense. The performance measure is the touchdown. And then we – the program is emphasizing and tracking how these performance measures are through time. You bring up a good point, Jesse is the fact that and of the completely translated here in your definition, you suggest that defining preparedness.

We're trying to hone it on and on what outcomes and speak to really where systems of care to deliver better outcomes. And that's what our change and focuses this year, and I think it probably needs to be reflected. And I'm hopeful that we can kind of integrate what we're doing on this call with where HPP is.

The only thing I think and what Gregg just spoke to healthcare systems, I'm not sure this, as I mentioned at the beginning of the call, I'm not sure this

should be hospital-centered. I think there needs to be, I think Gregg's right. I think health system center can – both players are identified in our first capability. I mean, it's the primary care doc and it's the dialysis center, it's the – along with the acute care level and trauma centers. So, I'll stop there.

Jesse Pines: Great. That's really helpful. Any other thoughts on definitions, and I think for a lot of this, David, we're going to rely on a lot of the work that's been done already with HPP. It sounds like a lot of these discussions have already happened. And I think our role will be to summarize that and to present that back to the group and whatever the current thinking is in those areas. So, it would be helpful to have all that information.

David Marcozzi: Yes, Jesse. It's Marcozzi. And we're wide open if you want to shift us right, shift us left because this group is a group of SMEs on the call. We're open to suggestions on that. So, it's certainly not hard a fixed performance measures that we think it's the best we got and its consensus driven and (inaudible) form. So, we're hopeful at least that you guys will find it, that there was some – there was one or two good products from the federal government.

Jesse Pines: OK. Thank you. So, next I wanted to shift a little bit into some of the data sources that might be available for some of these measures, and you know, what we found was several potential broad categories of data sources including drills and exercises, and essentially what drills and exercises are – are they tabletop exercise or sort of simulated?

What would happen if the disaster happen in your facility tomorrow and essentially, get that simulation of the different steps that an organization would take, and then there is some assessments of that that have been validated, particularly either internal assessments assessing how an organization sort of performed on that exercise or an external assessment of an objective view of performance.

There is certainly the actual response to events. There are several times that have looked at particularly within states that have looked at sort of how a state has performed over multiple disasters over a period of time. The best example

of that that we could find was at North Carolina which had some major storms back in 1999 and 2003, and those are nice studies.

They looked at sort of they compared the response before and after the 1999 storm where they sort of noticed where the holes were in their emergency response and they were actually able to address that, a lot of that through (inaudible) better systems. Those are potential data source although that would be sort of waiting for something to happen unless we you know – unless we sort of redefine our definition of disaster and include it either you know, in a really busy day in a hospital, how did the hospital perform versus a true disaster that would be – that would trigger some sort of a federal response.

And also some of the other potential data sources include – or it's called process observation and mapping which is again, similar to drills and exercises sort of doing an assessment of how a system might prepare for a disaster. And you know, I think that David and Gregg were sort of relying on you all here to tell us what you know – what other sources did you see as potential data sources? Are there things that we could think of would be you know, surveys of local public health department which would really more fall under the public health preparedness better than let's say, the health system preparedness?

But I want to open it up now and see what you all thought in terms of other potential data sources that we could rely on for – to measure preparedness.

Gregg Margolis: Jesse, this is Gregg. I know that you kind of turn to David and I on this. But candidly, I'd really like to – we've been having these conversations longer than (inaudible) but I really think one of the real benefits of this NQF process is getting new minds to think about this. So, I'd actually ask that maybe we take a little bit of a backseat and I'd really like to hear from anybody else on their ideas about potential data sources.

Male: Gregg, I know you mean not me when you said that but I guess I would just specifically ask if we don't have those folks on the call, we should also be – when we are still able to talk about who those folks at the state or local level

might be. Maybe, if the NQF folks could tell us before it's too late to sort of include them if we don't have the right expertise. And then you know, if the NQF folks are OK with it, if other people could suggest who they might.

And I saw Gregg (inaudible) and of course maybe he did a lot of work in this space and maybe some state directors might be very helpful.

Jesse Pines: In terms of our slate for the in-person meeting, we are somewhat restricted in terms of the number of people that we can have travel to the meeting. You know, through the process of reviewing the literature, we have actually come across several other individuals who I think could be helpful to review the report even if they don't necessarily sit in on the in-person meeting.

So, you know, we could certainly put together a list of other outside reviewers that we can send it to.

Male: One data source that we did a little bit in the previous (inaudible) project, I'm thinking about entry data has to (inaudible). When we spoke to David (inaudible) and one of the challenges to (inaudible) no EMS were organized either regionally or locally but I'm wondering if that thinking about potential EMS data sources falls – either response time or things like that falls within this preparedness study.

Linda McCaig: This is Linda McCaig from NCHS, and well I think it's (inaudible) year it was. A number of years ago, we did an emergency pediatrics assistant equipment settlement at The National Hospital and Ambulatory Medical Care Survey which themselves administered questionnaire and they gave it to some emergency department in the survey.

So, it is possible to add and (inaudible) for the survey but it takes a long time to get the results.

Ryan Mutter: This is Ryan from AHRQ. I know many of you all are familiar with the healthcare cost utilization project data but – I mean, it's another resource. I mean, basically what it gets you is for participating states. It gives you the universe of emergency department and inpatient encounters. And so you can see, you know, take a snapshot. This is what things look like, you know,

when it was called an ordinary day. This is what things look like, you know, if you know about some – now it's called a natural experiment. Some event that occurred, you know, Hurricane Irene in the Northeast. What facilities start to look like then?

It gives you a sense of what the landscape it. You know, what facilities are out there? What do patients flow look like? What do these facilities generally treat? And so, you know, it's information.

Jesse Pines: And Ryan, to me, thinking about the other data sources, certainly, you know, linking you know, some of the HCUP data could be linked to some of the facility of level data from the AHA survey or are there other sort of federal surveys that we could link to HCUP that could help, you know, that we could potentially use the data sources.

Ryan Mutter: Absolutely. You know, we have – I mean, you know, in the American Hospital Association Survey can be expanded and has been expanded in the past to do, you know, cover different interest areas so that capacity exists. You know, for example we've got – we're linked to the Trauma Information Exchange Program today because we have trauma center levels. There's a lot of stuff you can do to sort of build on that capacity.

Jesse Pines: Great. Any other thoughts for data sources, and you know, thinking broadly, you know, on our call yesterday, you know, we talked about crowding measures yet again to expanding from throughput measures to potentially input and output measures. But thinking similarly about preparedness measures, you know, thinking about our wish list, what sort of information would we want to have if you know, if a data system could be developed, and thinking more broadly about this. Any thoughts about you know, trying to get a hold of this concept for data sources that may not exist that could be developed in the future?

Jeremiah Schuur: Jesse, J. Schuur. I know joint commission was mentioned in the report particularly around the flow standards but as you know, the organization at surveying hospitals, the majority of hospitals they're obviously that other couple of accreditation organizations but that's a potential data source that

could be – it could work for those organizations and have preparedness measures built in to their reports.

Jesse Pines: That's an interesting idea. I don't know how familiar everyone is with the joint commission patient flow standard but just to clarify there. So, the joint commission patient flow standard was updated earlier this year. There were several additional elements that were added mostly around boarding and basically the hospital should have a system to measure and should – that that information should get to the leadership and if it's a problem that hospitals should develop and actually plan.

It also specifically focus on behavioral health patients as a high risk group and having a specific plan around behavioral health patients and working with community providers to make sure the people are treated efficiently and get good care.

As far as I know and maybe I don't know if anyone else knows of the specific joint commission standards that are available for preparedness or rather the any joint commissioner standards that are in the process of being developed in this area.

AnnMarie Papa: Jesse, this is AnnMarie. Aren't there other standards also in the leadership chapter for the joint commission with regard to managing flow and managing surge and those kinds of things? I forget the number of them off the top of my head but that's in the leadership chapter.

Jesse Pines: I think the flow standard actually does fall under the leadership chapter. What I talked about was the sort of the additional elements of the patient's flow standard which we're adding in 2012. Some of the existing elements did do involve leadership around dealing with crowding and boarding.

AnnMarie Papa: Great.

David Marcozzi: Jesse, it's Marcozzi. There are certainly a lot of difference joint commission linkages to the preparedness, you know, there's – I won't cite them all but there's you know, em.01.01.01 and subsequently 02.0101. There are multiple different areas in the joint commissions work. There's also some language

and some consideration in and around because this is participation at a high level for CMS participants, and a higher level for CMS standards in and around emergency preparedness.

And there are some discussions around that, and some of those conditions have been embedded in but are – but continue to be embedded internal to CMS. So I know that there are discussions internal to HHS house and externally obviously to the joint commission where we could look towards different areas of measures for preparedness.

Jesse Pines: Dave, that's very helpful. Other thoughts on data sources and potential data sources or other systems that could be developed to measure preparedness.

Manish Shah: Jesse, this is Manish. One thought that I had, I don't know if tapping into the American College of Surgeon reviews for at least a trauma centers may give at least a shot at sense of capabilities within the trauma center type hospitals. I mean, they actually do a fairly detailed review.

Jesse Pines: That's an interesting idea. Can you be more specific? So, what would that look like?

Manish Shah: Like if we're seeing a kind of the capabilities of this facilities, what level of resources are available, it's going to be kind of a little bit of a superficial way to the community that you're not going to get all the information at all the hospitals but at least from a trauma standpoint, you might get a sense of – and I don't know how detailed their data is. New York's just finally getting into the ACS verification mode.

But I just wonder whether they may have some further information about the extent of ICU capabilities, equipments available down to subspecialty available and stuff like that but maybe useful in terms of existing resources.

Jesse Pines: That's an interesting idea and we can definitely look into that.

Manish Shah: And Jesse one other idea is we've kind of – I know I've found a draft report resolutions to the use of these measures as being beneficial for surveillance or the leading indicators of an incident. I'm just wondering if maybe you want to

think of future data sources, thinking about whether or not these measures were part of you know, Stage III of meaningful use or something like that.

And then we actually get to a point where when we are electronically capturing this data and you have it in an inoperable format that can be aggregated then you have actual (inaudible) to then use it for surveillance.

Jesse Pines: That's in interesting point. Other thoughts on data sources that we didn't think of? This was really helpful and it gives us a lot of good idea and also a lot of things that we're going through the draft report for the in-person meeting.

So, we still have a little over a half-an-hour here and I also want to spend some time talking a little bit about regionalization and sort of what that means for our report and in general, for measurement. And then, I also wanted to spend a fair amount of time thinking about what a consensus development process would look like for developing crowding and preparedness measures. And specifically thinking about who are actually –who actually developed these and what sort of a tool kit would they need? And also, how might we modify the NQF standards for preparedness measures in particular?

We don't have a document yet but we will certainly share that with the group. There are a couple of things, so essentially, we're going to – we can send everyone the side-by-side of the how the population from the population health project, and how the population health measures were modified for the issues of population health as example. And also, sort of a draft of what we think would go into the modification of NQF standards for the preparedness measures.

So, that's sort of our next 35 minutes if we need that long. I wanted to maybe move to the issue of regionalization and how we can you know, put sort of an additional frame on this, and then maybe Brendan, if he could talk a little bit about you know, this is your area and what your thoughts are.

Brendan Carr: Do you want to start there?

Jesse Pines: Yes, go ahead.

Brendan Carr: So, you know, I think you actually covered it, and I don't think there's a whole lot more to say. The concept that we build in to each of these some ability to bring them – to look at them not at the local level but to look at them at a broader level is exactly the intent there. And I think we talked about even when we were talking about preparedness and I swerved into that when I was talking about what (inaudible) will have to say about the fact that there's not a clean line between day-to-day and disaster day.

But at the end of the day, I think that we're going to have to take on headlong the issues of geography that has not really been in any way definitely addressed. We don't know – still don't know how you sum things. And I guess I would say that I think there's probably some good – I hope there's some good synergy with the healthcare coalition initiatives as those start to collect, as we start to understand how hospitals and other health systems participants think they aren't connected to each other. To understand what their markets are, we might start understand what this – the (inaudible) is going to be that we'll look at outcomes at.

Jesse Pines: Great. Brendan, that's really helpful and we have reached out to a few geographers to be on the panel. I don't think, and maybe Angela can clarify or Adeela whether we are going to have any geographers in the in-person meeting but we could certainly plan to send the draft report or at least have them review the section of regionalization.

(Angela Franklin): We don't have the geographers right now. They were conflicted though with time. So, we hope to be able to send that draft to them for reaction.

(Brendan Carr): Maybe we can – I know I already (inaudible) on this, sorry. But I think we – we might need their input before we have a draft ready to go. I just don't think many of our minds work on the same way that theirs do.

But you know, they would talk about how patients flow and understanding how patients flow defines for us most likely what the region's going to look like. So, if there are (empirical) ways to determine patient flow, and they can think of them, at least around sort of you know, (all kinds of) illness, and those are going to be, I think important things to take into this.

It's interesting, so essentially, we have the current units of geography that are out there from you know, large regions to counties, to different you know, hospital service areas. Beyond that, you know, there are certainly some level – always a boundary and you know, where we're going to have one hospital at one side and one hospital on the other that are close in proximity. How much do you want to really address this to the broader geographic issues or just to sort of save it when these measures are developed and (inaudible) that there should be some level of (regionality) to them.

Well, I guess, you know, without a geographer, in closing, how much can we really sort of (advance) in this area?

Jesse Pines: Yes, I agree with you. I think what you just said was that perhaps that is outside of the scope of this, and I actually agree with you. I think it's a giant body of work that's someone needs to take a deep dive on and probably this isn't the group but – so, it would probably be fine to start by saying, "Look, we don't think that's knowing what's happening at one hospital in my city, in my county, in my tri-county area, in my region, tells us a whole lot about preparedness."

Gregg Margolis: This is Gregg Margolis. I just kind of add to the conversation. You know, I think kind of the question to me is what is the emergency care or unit of analysis that is analogous to the way (inaudible) looks at some issues regarding healthcare. So, you know, they have the hospital referral regions and the hospital service areas, and then the primary care service areas.

You know, and I wonder to what extent – it would great, I think if we get people's brains to start thinking about are the, I don't know, emergency care referral regions or emergency care service areas, or emergency preparedness service areas; are they the same as, different than, how close are they maybe to some of the existing units of measure for other geographically based healthcare measurement work?

Ryan Mutter: This is Ryan. One of the things you could do is sort of take analogous concepts so you could sort of say, "OK, we're going to base it around level one trauma centers and we're going to basically extend our radius out from a

level one trauma center until it captures, you know, 75 percent of the – I don't know injuries that go to that trauma center, right?" And that's sort of the space around. There are things you can do like that.

At least take an – instead of it being something like, you know, where the Medicare heart attack patients go. It's sort of where do the injuries go or something like that.

(Brendan Carr): Well, yes, but you know, then we had to determine how to share the space because just as Jesse said, there's going to be a boundary and that boundary is going to be blurry.

And you know, as you get further and further away from the facility, you're going to start sharing more and more space with the next facility. So, I agree. That is good work. I would say two other things. The first is, Jesse, I actually think you're right that although we can maybe talk conceptually about this, but we're not the group to get this done, number one

And number two, I think that we should really be thoughtful about how we can bring to this into a dialogue that's already happening instead of reinventing one. So, I'm interest to know more about the population health projects that you guys just did, for the large because I think this is population health.

It's just population health for unplanned stuff instead of population health for public health stuff. It's the way you usually think of it or you know, instead of just in our hospital (inaudible) regions for (inaudible) we're now talking about an unplanned (disease).

So, I think we can learn from them and we should probably borrow some of the language around population health.

Jesse Pines: Sure and what we can do, Adeela, if you can send out the population health report and also the figure that sort of shows the NQF standards and how they were adapted for population health for the group to be read.

Adeela Khan: Yes. I'll send that to you guys right next week.

Jesse Pines: Great. Any other comments of regionalization and geographies? This is really helpful. You know, Ryan, you mentioned some other ways that we could potentially measure regions carefully certainly within with an HCUP data. Any other ideas that you know, included so that geographers could think about in a medical model that we could use?

David Marcozzi: Hey, it's Marcozzi. Jesse, just to let you know, we are (inaudible) with a lot of the same questions that are coming up on this call and we're literally thrilled and I'm glad that the team here on the call will help in forming the process moving forward. But just to let you know that we're conducting survey to try and answer the question in and around what are coalitions define as their respective coalition areas.

Is it geographical? Is it referral based? Is it trauma based? Is it an EMS system based? Because we don't have a handle on that yet from an HPP standpoint and we're going to try and look to build that in.

So, hopefully that survey may help this effort overall, just wanted to let you know about that.

Jesse Pines: That's really helpful. Anything you can send, maybe a copy of the survey or any sort of – anything that you are able to share, we'd love to see.

David Marcozzi: Yes, will do. Sure. As soon as I get off the call, I'll try to (bring over) the right people.

Jesse Pines: Great. Any other comments on regionalization. So, the next – I wanted to talk a little bit about what an intensive development process might look like. And maybe, I don't know Angela, if you want to describe what sort of a consensus development process looks like, and to think about – there are a number of sort of unique issues that we would have to deal with you know, how we would specifically structure that.

Secondarily, and I think the important to this group discussion is, who are going to be the measure developers to prepare this measure? And what sort of a toolkit do they need to do that through the NQF. I know, David, you said

that there's a lot of work that's going on though HPP and ASPR. But thinking more broadly, do we want to you know, we have folks from the CDC on the call and also from AHRQ.

Who else can we think of who would really want to sort of bring in the (gold) when sending out this (quality) measure? So, Angela, why don't you maybe just briefly describe (inaudible) high-level consensus development process would look like and then we could open it up for a discussion on what that would look like and specifically when it came through (crowding) preparedness.

Angela Franklin: OK. Sure, I'll go over generically what our – to see what the consensus development process looks like. We don't have you know, the follow on work for this hasn't been kind of thought of yet or thought of by our senior executives here yet in terms of taking it up.

But for the consensus development process, we would – certainly convene again the panel of stakeholders across the broad range of our councils. And we would have them walk through for the measures that came in. All the criteria in our – that are required in our CDP process and that would mean that each measure that we look at would have to meet certain criteria for importance in particular, whether the evidence base is there, whether there's a gap in performance and whether there's outcome link to the particular process or structural measure.

So that's, you know, the high level pieces of it and just you had mentioned that we have a side by side from population health. And that lays out the specific criteria that these measures will be looked. The problem comes when we raised these levels – when we raised these measures to the population level and those areas of importance and evidence base as well as testing to ensure the measure is reliable and valid could become problematic.

So we're looking to, as Jesse said, put together our wish list of measures we'd like to see, identify and prioritize the measures we'd like to see in certain spaces and also provide guidance to the field about how the measures would possibly meet to NQF criteria.

I'll pause for a second for questions.

Any questions so far?

Male: Yes. Could you maybe walk us through an example from the population health piece? Because they also grapple with the fact that most of the folks in this space don't think about their challenges and don't think about things the way they think about things, right?

Female: That's correct. That's correct. So opening it up, the criteria for evaluation for example, let's see, so for under the heading of importance and we're looking at the impact opportunity and the evidence base for the measures, measures are supposed to meet all three of those based on specific criteria that flow out of that.

And for the population health piece, the measure still have to be evidence based, still important to making significant gain and improving care but specifically at the population level and it is more detailed about that, related specifically to population health. And the third thing improving determinants of health and health outcomes of a population is a slight adjustment to the criteria that NQF has. Still, each measure has to meet all three of those pieces, evidence base important to making significant gains and improving care and improving the determinants of health at the population level. All three of those must be met before the measure can move on.

Let me give another example of high impact. Generically or currently under our NQF process, the measure focus has to adjust a specific national health goal or priority identified by the national priorities partnership or in the national quality strategy. And then for population health in particular, high impact might be enough to (pass master) here. In our case, we might look at the possibility that there was a high impact that was addressed or – that was addressed under the national prevention strategy – oh, I'm sorry – under the security strategy piece.

So there's some caveat that we can make without really substantially changing the underlying criteria that NQF requires for each of the – for each measure.

Female: Right. And I can just something here. What's the working on kind of, you know, extrapolating this sort of criteria to regionalized medicine framework? We have to work with – we're still working with our methodologies here in NQF and we'll probably have something for you at the in-person meeting to react to…

Female: But beside to that, we'll have the side by side next week to take a look at where these modifications could be made, but by keeping – but still keeping, you know, the robustness of the requirements for measure endorsement.

Jesse Pines: Great. And also I think what might be helpful is to, you know, take, you know, you take some of those HPP measures and sort of do some test runs even in terms of what those might look like again the NQF standard. You know, I think that would be something that we would do at the in-person meeting.

Great. Any other questions, comments about sort of the process of what consensus development process would like be? You know, again, we don't have the (trap) side by side yet so there's nothing to comment on it at this time, but we will have that soon and have that hand to them group for general comment.

And again, to clarify, we're not planning on lowering the standard but we're just merely modifying it to more conform with the unique elements of – the unique measurement issues and preparedness.

And also I just wanted to think broadly and help, you know, get some brains from the group in terms of who all could potentially develop these preparedness measures outside of the federal government, you know, thinking about, you know. Really, maybe the measure developer would be – would be as per or contracts through as per, but who else could we reach out to potentially thinking of other federal and non-federal agencies that might be interested in developing measures.

Ryan Mutter: Jesse, this is Ryan. I mean, there's some work going on at AHRQ around potentially preventable emergency department encounters, ED patient safety indicators and things like that in which it's not the same space but it's related.

Jesse Pines: OK? Well, I think that's a good point. I mean, you know, particularly when we – when we still got the whole potential consensus development process, we have to – we want to stay upfront what sort of fit within crowding, boarding and preparedness and what doesn't. And, you know, that's really the group can decide to, you know, we could make recommendation to expand the scope a little bit. And so what potentially captures some of those measures, well probably we could, you know, keep it focused more on the issues at hand.

So are there thoughts about the, I think Brendan, you termed the runway and what that looks like?

I guess to sort of broaden the question, what, you know, what information that doesn't exist now should be – should be generated to that there might be missing to meet some of these NQF criteria? Certainly, you know, additional evidence generation relating to some of these preparedness concepts to outcomes would be ideal? I think that might be a wishful thinking particularly even if it this happens in two or three year that we would really be there in terms of the evidence generation. But essentially what I do want to get into the report is what the group thinks are potential sort of next steps that would be needed before the consensus development process could actually happen.

And I do realize that it's 10 to 6 on a Friday. So any additional comments? So I think we're pretty – we're getting near the end here. Any additional comments or other issues people wanted to bring up? (inaudible).

OK. Then…

Brendan Carr: Jesse, this is Brendan. This is Bren.

Jesse Pines: Go ahead.

Brendan Carr: I just think that last week that you're sort of talking through now. We need to make sure we maybe put it on the agenda some more sort of on the front end so that we can really focus on it. Because I think that in part we don't know the answer to those questions as a problem. It just means that the report falls

on deaf ears and I think that some help from the NQF and help from (Jay) and Arjun and Brent, the folks would know, you know, who this quality – who the metric makers are, we probably really should target the list and figure out who it is that we're going to send this report to and say, "You're one of five people in this space. If you don't do it, it's not going to happen."

So I mean, I get that this wait and I get that, you know, maybe people have already losing energy, but we can't ignore this otherwise this will just be a report that gets to the shelf.

Angela Franklin: All right. This is Angela. We'll definitely – well, we can do that internally with your staff. I think we had talked about it early on when we were kicking off the project, but we haven't focused on it yet so we can see this up for the in-person meeting with some further input from our senior staff.

Arjun Venkatesh: This is Arjun. Yes, I guess on the same plan, I don't know how – I'm sure that the agenda is packed, but getting to what Brendan was kind of alluding to, do you think that some of the realities for measure development into space and successfully taking measure from concepts to endorse. It may be valuable as we kind of repeat the exercise you're eluding to here Jesse with an actual measure – with the actual measure evaluation criteria up on the screen in the in-person meeting.

Because I think it will at least raised issues primarily on the scientific acceptability part and then some of the new must-pass criteria around, you know, how close the linkage turn outcome is, how well it has been -- that linkage has been proven that was going to challenge for these measures. And I think that would made discussion much easier in person when you're actually looking for specific criteria.

Jesse Pines: OK. I think that's a great point and certainly by the in-person meeting we'll have that and we'll have that well in advance so everyone can review that for a good discussion.

Any additional comments? I think everyone – well, anyway, so I'd like to thank everyone for their attention. Let me go ahead and turn it over to Adeela and Angela for any closing and public comment.

Angela Franklin: Thanks. Actually, we'll open the line for public comment at this time.

Operator: And at this time, if you would like to ask a question, please press star-one on your telephone keypad.

There are no questions at this time.

Adeela Khan: OK. So we're just going to go over to Next Steps. You should have all received travel logistics memo from our meetings department. Just please make sure that you are (CP) for the meeting. There's some important guidance on travel and booking travel and we just want to try and get that done as soon as possible.

Other than that, next week we'll probably be sending you some more materials and another draft for you to react to and that one will send as a Word document so you can actually do track changes and we'll have like a deadline set up for everyone to send it back to us in time for the in-person meeting.

But other than that, there's nothing else on our end. So you're free to go and enjoy your Friday. Thank you all for calling in and we'll talk to you soon.

Thank you.

Jesse Pines: Great. Thanks, everyone.

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

END