National Quality Forum

Moderator: Trauma Outcomes
August 21, 2018
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OPERATOR: This is Conference # 3884415.

Christy Skipper: Good afternoon, everyone, and welcome to the Trauma Orientation Web Meeting.

My name is Christy Skipper, and I'm the project manager on this project. I just want to say that we're looking forward to meeting you all in the next couple of weeks at our in-person meeting. But, before that, we need to let you all know what this project is about and what we'll be doing over the next few months.

So, just a quick background. And we'll start out with a quick background and overview of NQF and an overview of the project and give you an overview or an introduction to the environmental scan. Throughout the call today, we'll let you ask any questions that you have about the project, provide input on the approach to the environmental scan or any other topic that you all want to discuss related to the Trauma Outcomes project.

With all of our meetings, we do allow an opportunity for public comment. All of our meetings are open to the public. So, we will take some time out toward the end of the call to hear if anyone else on the line has any questions for us. Then, we will move to a SharePoint overview. SharePoint is the platform that we use to house all committee documents. And, then, we'll close out with a couple of next steps.

So, now, we'll move on to staff introductions. And, then, I'll turn it over to our committee members to give a brief introduction of yourself. So, again, my name is Christy Skipper, and I'm the project manager on this project.

John Bernot: Hi. My name is John Bernot. I'm vice president of Quality Measurement Initiative. And I'm really excited to get started on this project. I worked on a few framework projects as well as our endorsement work and some other activities within NQF.

I am a family physician, so I am particularly interested as I see patients come through after trauma and the repercussions and also the benefits of whenever things went really well. So, I'm really interested to see how this project will unfold. I'm looking forward to it. I'll be with us for most all of the meetings going forward.

Elisa Munthali: My name is Elisa Munthali. I'm the senior vice president for quality measurement at the National Quality Forum. I oversee the framework project like this, the endorsement work, and I work on measure selection. And I just wanted to thank you on behalf of NQF for serving on this committee.

Jean-Luc Tilly: My name is Jean-Luc Tilly. I'm a senior manager here at NQF. And I work on a few different framework-type projects, including the Measure Variation project with my colleague Andrew Lyzenga.

Andrew Lyzenga: Yes. This is Andrew. I'm a senior director here at NQF. I've been at NQF since about 2009 and worked on a pretty wide variety of projects here. I've focused a lot of my work on patient safety but on a number of other issues as well. Looking forward to this project.

Christy Skipper: Great. Thank you. So, now, we'll move on and just run through – hear who all is on the phone. And we'll start alphabetically with Robert Bass. If you could introduce yourself, tell us a little bit about yourself. Robert Bass, are you on? OK. Derek Bergsten?

Derek Bergsten: Yes. Derek Bergsten. I'm the chief of the Rockford Fire Department in Rockford, Illinois, just about 80 miles northwest of Chicago. We're the second largest fire department in the state of Illinois and provide ALS service,

transport roughly about 22,000 patients a year. Looking forward to work (with – on the) committee.

Christy Skipper: Welcome. Thank you. Bryan Collier?

Bryan Collier: Yes. My name is Bryan Collier. I'm the trauma medical director for Level One Trauma Center in Southwest Virginia in Roanoke, Virginia. And, again, looking forward to work with everybody. Thank you for the opportunity.

Christy Skipper: Joseph Cuschieri?

Joseph Cuschieri: Yes. Hi. I'm Joseph Cuschieri. I'm a professor of surgery at the University of Washington. I am the medical for our surgical ICU here. And looking forward to working on the committee.

Christy Skipper: Thank you. James Eubanks? Alexander Garza? Michael Gonzalez?

Michael Gonzalez: Hi. This is Mike. And I'm an emergency physician in Houston, Texas. I'm also the associate medical director for Houston Fire.

Christy Skipper: Welcome. Adil Haider?

Adil Haider: Hello and good afternoon to everybody. This is Adil Haider. I am a professor at Harvard Medical School and lead the Center for Surgery and Public Health. I am a practicing trauma surgeon and I work at Brigman and Women's Hospital and have been working on trauma outcomes development for about nearly two decades and was involved in the Institute of Medicine report on the military learning health system and how it can be used to improve civilian trauma care.

(Recommendation number six of that report – or – was specifically this, to develop trauma outcome measures). And (inaudible) on the NQF. And, so, (inaudible) more thrilled that this is finally happening.

Christy Skipper: Thank you. Kurt Hoppe.

Kurt Hoppe: Hi. This is Kurt Hoppe. And my name is misspelled. There should be two Ps. I'm the medical director of Mayo Clinic Rochester Rehabilitation Unit and chair of the Mayo Clinic Interdisciplinary Spinal Cord Injury Committee.

Christy Skipper: Welcome. And we – I will fix that. I apologize for that.

Kurt Hoppe: It's all right.

Christy Skipper: OK. Elliott Haut?

Elliott Haut: Hey. How are you doing? I'm Elliott Haut. I'm a trauma surgeon at Johns Hopkins. I am also interested in qualify safety as it relates to trauma care. I was glad Dr. Haider mentioned the Institute of Medicine report. We did a small piece on data usage for trauma system that ended up as an appendix to that report.

Hopefully, we'll be talking about that. Although I'm not an official EAST representative, I am the president-elect of EAST, which is the Eastern Association for Surgery and Trauma, for those of you who don't know about that group. And I'm excited to be on the call.

Christy Skipper: Welcome. Thank you. Gregory?

Gregory Hawryluk: (Great. Hi). Gregory Hawryluk at the University of Utah. I am the director of neurotrauma here. I believe I am the only neurosurgeon on the committee. (I'm also basic) (inaudible) (and I write along with the guidelines) for both head and spinal cord injury management.

Christy Skipper: Welcome. Thank you. Carol Immermann? David Livingston?

David Livingston: Yes. Hi. David Livingston. I am the chief of trauma surgical critical care at the New Jersey Trauma Center at Newark and Rutgers new Jersey Medical School. I'm been a trauma surgeon now for 30 years. And both short- and long-term trauma outcomes are the area of research of mine, and development of practices to this is really a life-long goal. I appreciate being on this committee.

Christy Skipper: Thank you. Barry Markman?

Barry Markman: Good afternoon. Hi. I'm a board-certified plastic surgeon. And I currently am I senior medical director with Aetna Medicaid. And I'm crossing over the Surgical Committee of the National Quality Forum – Surgical Committee to participate in the Trauma Committee. I'm very excited to do it.

Christy Skipper: Welcome. Thank you. Linda Melillo? Anna Miller? Sage Myers?

Sage Myers: Hello.

Christy Skipper: Hi. Good afternoon. Hi. Is this Sage? OK. Avery Nathens?

Avery Nathens: Hi. I'm Avery. I'm a trauma surgeon at University of Toronto. And I also am a medical director of trauma quality programs at the American College of Surgeons where I oversee verification of TQIP. And I've been involved in some way with trauma measurement and trauma quality outcomes my entire career.

So, I'm very happy to be a co-chair of this – of this committee. And looking at the list of participants, I see we truly have an all-star cast with a great degree of representation. So, I'm thrilled to be involved.

Christy Skipper: Welcome. Thank you. Craig Newgard?

Craig Newgard: Yes. My name is Craig Newgard. I'm a practicing emergency physician at Oregon Health and Science University in Portland, Oregon. And I direct a research center here.

My research focus has been on trauma systems and trauma outcomes, also looking at quality metrics and the cost implications of trauma systems and with particular focus from (none on one) system, ambulance transport patterns, interhospital transfers and the like. I served on the last expert panel for revising the National Field Triage Guidelines. And I greatly appreciate being on this group. Thanks for having me.

Christy Skipper: Welcome. Thank you. Jack Sava?

Jack Sava: Yes. Hi. I'm Jack Sava. I'm the chief of trauma at a trauma center here in the District of Columbia and active in a bunch of local trauma stuff here.

Christy Skipper: OK. Welcome. Thank you. Andrew Schrag?

Andrew Schrag: Yes. This is Andrew. And you got my name right. Thank you. I'm a regional director for Partners Behavioral Health and a licensed professional counseling supervisor. And just appreciative to be on this panel as a part of the behavioral health component of trauma.

Christy Skipper: Welcome. Thank you. David Seidenwurm?

David Seidenwurm: Yes. Hi, everyone. I'm David Seidenwurm. I'm a neuroradiologist by trade. So, I'm interested in trauma outcomes from the predictive point of view, of course. My day job is network medical director for Sutter Health (valley region). And, so, we handle just under a quarter of a million (managed lives), about (100,000 full risk). And so, again, interested in trauma outcomes from that point of view as well.

Christy Skipper: Thank you. Theresa Snavely?

Theresa Snavely: Hi. This is Theresa Snavely. I am currently working out of the Pennsylvania Trauma Systems Foundation as manager of performance improvement in Camp Hill, Pennsylvania. The PTSF is the accrediting body for trauma centers in Pennsylvania. And I've been involved in trauma care now for 37 years as a nurse. So, I'm very happy to – and privileged to work with this group. Thank you so much.

Christy Skipper: Thank you. Peter Thomas?

Peter Thomas: Hi. This is Peter Thomas. I'm a lawyer practicing rehabilitation and disability law and advocacy in Washington, D.C. I'm a former trauma survivor. I guess you could say I was in a car wreck when I was 10 and lost my legs below the knees.

I serve on the American Society – America Trauma Society as chair of their Trauma Survivors Network, which is a patient-centered approach to trauma care with an emphasis on peer mentoring. And I also am a co-investigator on a trauma grant that's funded by – funded by (McCoury). So, I'm very pleased to be participating.

Christy Skipper: Welcome. Thank you. Garth Utter?

Garth Utter: Hello. I'm a professor of surgery and practicing trauma surgeon at the University of California, Davis. I have been most familiar with NQF's work through the past decade or so. I've been supporting AHRQ with their quality indicators, namely the patient safety indicators. So, I'm happy to contribute to this effort.

Christy Skipper: Thank you. And I know that we did call a couple of names and I know that people may have now had a chance to dial in. So, I'm just going to go back through the list. Robert Bass, are you on?

Robert Bass: Yes. Christy, can you hear me OK now?

Christy Skipper: Yes, I can hear you.

Robert Bass: Sorry I had a technical issue starting out.

Christy Skipper: OK.

Robert Bass: I apologize. I'm an emergency physician with a special interest in EMS and systems of care. Most recently, I spent 20 years as a director of the Maryland Institute for EMS Systems, which is the trauma and EMS system for the state of Maryland, a fairly mature system. Since I retired from MIEMSS, I worked on the EMS Compass project developing performance measures. I was chair of the Steering Committee.

And over the years, I've work on other committees at the Institute of Medicine trauma and EMS reports and with CDC on field trauma triage and with ACS COT on optimal resources et cetera. And I'm very, very excited about this project (and would like to) thank you for including all of the pre-hospital

providers as well as the trauma surgeons, emergency physicians et cetera. Thank you. It's going to be a great group to work with.

Christy Skipper: Thank you. OK. Did James Eubanks join?

James Eubanks: Yes. I'm here. My name is James Eubanks. Most people call me Trey. Being from the south, (to be a third), you get the name Trey or Trip. So, I'm from Memphis, Tennessee. I'm a pediatric trauma surgeon. And I'm currently serving as the surgeon-in-chief of Le Bonheur Children's Hospital, which is a University of Tennessee Health Center affiliated teaching hospital.

I've been the trauma medical director here for eight years and just handed that over to one of my junior partners. And we are a level one trauma center for pediatric trauma for Arkansas, Tennessee and Mississippi. I also serve on the Board of Directors for TCAA and, as a trauma surgeon, have been very active in working on pediatric trauma outcomes, which I am afraid we're a little bit on the adult side, and injury prevention as well. I'm very excited to be working with this group and looking forward to working together.

Christy Skipper: Yes. Thank you. Welcome. Alexander Garza?

Alexander Garza: Yes. Hi. Can you hear me?

Christy Skipper: Yes.

Alexander Garza: Yes. Hi. Thanks. Dr. Garza. I'm an emergency physician by training. Prior career in EMS as a paramedic and flight medic. Twenty years in the Army Reserve as a surgeon. My most recent position in this – the system director for quality for SSM Health, which is a fairly large midwestern health care system with four trauma centers in it. Previous career in the federal government as chief medical officer for the Department of Homeland Security. Thanks.

Christy Skipper: Welcome. Thank you. Carol Immermann?

Carol Immermann: Yes. Good afternoon. I'm Carol Immermann. I'm the – currently the trauma program manager at Mayo Clinic in Rochester, Minnesota. We're a

level one trauma center and also a level one pediatric trauma center. A little bit unique with us is that, you know, we're a large facility in the middle of a corn field. So, while you might think of us as being urban, we also – typically, we have – you know, most of our patients are referred in from very rural areas.

By background, before I was in Minnesota here, I was in Wisconsin at a level three hospital and also the trauma program manager for a level three and two level fours, prior to that in Michigan at a level one trauma center (and gun club there).

So, very excited to see this and especially as we are looking at trauma systems not only in the big cities but, you know, when we get to our urban – I'm sorry – our rural and frontier areas, again, what might be best and how can we get best outcomes for them. So, thank you for inviting me to be on this.

Christy Skipper: Welcome. Thank you. Linda Melillo?

Linda Melillo: Yes. Hi. Thank you very much. So, I have over 15 years as a patient experience professional. And most recently, I worked at a rural hospital system in Pennsylvania, Penn Highlands, as the system director for patient experience and also, prior to that, at a partner's post-acute sector with (Solving) Rehabilitation. And I have a background in quality, patient safety, risk management, and I have a degree in – a masters in health law. I'm really looking forward to this group. And thank you.

Christy Skipper: Welcome. Thank you. Anna Miller? Sage Myers? OK. All right. Well, that being said, I will now move on. I want to note that this work was funded HHS. And we do have some of our federal contacts on the line. So, if we could start with CMS, if you'd like to introduce the staff that's on the line. I believe – Nina Heggs, Sophia Chan, David Jefferson, if you are on the line and you'd like to introduce yourself.

Nina Heggs: Hi. This is Nina Heggs. I am the core contracting officer representative (for the) (inaudible). I'm also a health insurance specialist with CMS. On behalf of CMS, I would just like to thank everybody for participating in this body of

work, and I look forward to working with everyone. I'm not sure if – Sophia, are you on? I know my deputy director is on. Melissa Evans, would you like to say something?

Melissa Evans: I think my line is muted. Can everyone hear me?

Male: Yes.

Christy Skipper: Yes.

Melissa Evans: Perfect. Melissa Evans. I am the deputy division director for PPMS with CCSQ. I've been a lot of different places within CMS. But, I hold a Ph.D. in econometrics basically and have done a lot of research on pharmaceuticals myself and came to quality out of just a sheer interest in outcomes and things of that nature. And that's all I have.

Christy Skipper: OK.

Nina Heggs: Thanks, Melissa. And I'm not sure if David is on. But, David is the contracting specialist. He may not have been able to join us today.

Christy Skipper: OK. Thank you. Our contacts from ASPR, Brendan and Jessica?

Brendan Carr: Hi, everybody. This is Brendan Carr. I'm the emergency physician and I'm the director of the Emergency Care Coordination Center. We are the sort of shop that brought the topic area to CMS to sort of sponsor through NQF.

Jessica Couillard: And this is Jessica Couillard. I would with Brendan in the Emergency Care Coordination Center. And we are really thankful and excited to getting started on this project. So, thanks for joining.

Brendan Carr: I think Matt Cogdell is on with us as well.

Christy Skipper: OK.

Matt Cogdell: Yes. This is Matt Cogdell at ASPR Emergency Care Coordination Center. We support this project as well. Thank you.

Christy Skipper: Thank you. And I believe, Brendan, you have some remarks you'd like to share. Can you see the slide in front of you?

Brendan Carr: Yes. Thank you. Sorry about the delay in getting that to you. And, hey, everybody. So, I just want to take a couple of minutes to thank you on behalf of ASPR and to talk a little bit about the origin to this. This is a – this is a wonderful group. I mean, there's folks that I've known for a very long time on this call and some folks that I don't know yet. And I know that this is sort of the right group to march this process forward.

So, I direct the Emergency Care Coordination Center. For those of you who don't know who we are, it's ECCC at ASPR. ASPR is the Office of the Assistant Secretary for Preparedness and Response, and it's where trauma and emergency care live in the federal government within Health and Human Services.

The focus specifically within ECCC is to think about bridging day-to-day emergency care into the larger disasters and public health emergencies that are the broader focus of ASPR. Sort of along those lines, the new ASPR in this administration has four key priorities, three of them not really our job right now. The fourth is (center mass) for this NQF process.

So, the first is to offer sort of strong leadership for the health care response activities within the federal government. The second is to think about public health securities and capabilities. The third is to think about the medical countermeasures. And they are required to respond to events.

And the last is ours. The last is to build a regional disaster health response system that sort of builds upon trauma systems and emergency care systems to make sure that the American public is as – is as protected as possible during challenging times.

So, there are – the map here in front of you is a notional – that is – that is my way of saying if that blue cross is somewhere you don't like it or that red cross is somewhere you don't like it, it's OK because it doesn't exist. So, just to take a second to walk through this.

We are trying to build – you know, this is a group that I think, you know, very much understands transparency and tiering of capabilities and responsibilities. The light blue lines on here are health – for those of you who are familiar with the Hospital Preparedness Program at ASPR, those are health care coalitions.

And those are sort of groups that have said, "This is our community. This is our geography that we're looking out for. And we will work together as a team – all the assets within this – within this coalition in order to make that happen." That does exist. HPP does exist.

The blue crosses are sort of notional. Those are state disaster resource centers. And the red ones are regional disaster resource centers. There is a funding opportunity announcement out now. We shared it with the NQF folks.

And, you know, in the – in the former process, the funding opportunity announcement is to build two regional disaster resource centers to sort of figure out the logistics of having them help to serve as a coordinating entity for their states and for their regions. I'm happy to talk more about that afterwards.

I just wanted to say that, you know, one other initiative to draw your attention to is that we recently – ASPR recently sponsored national academies initiative, another one that was about engaging the private sector in health care delivery.

And we know – (it is not lost on us) that health care is delivered by the private sector, not by the federal government and that the incentives, frankly, to be a part of the trauma response system of the disaster response system of the readiness infrastructure for the U.S. aren't what they might be.

There are many more incentives to not do that than there are to do that, which brings us to this task. One of the things that I think will drive the health care sector to be engaged is to think about increasing the way that we think about quality measurement in this space, in the broader space, for sure, but, for our purposes on this working group, to think about trauma care.

But, I wanted to say we are asking – and this is important. We are asking that this group think differently about attribution for injury and for trauma care than we do often in the quality space.

So, typically, the denominator that we focus on comes from a payer perspective or a provider perspective. A concrete example would be the ICU Catheter-Associated Urinary Tract Infection Rates, you know, for my ICU or the Hemoglobin A1C Rates for my patient panel – things like this.

We are – we are asking this group to think about injury outcomes from the population or the community's perspective. As you all know, trauma care doesn't follow health system affiliations, insurance networks, provider referral patterns. And using these as the denominator for a community or population within trauma may not make sense.

The recent – you know, the recent military report from (MILSIV) report that was referenced a couple of times – you know, Dr. (Burrick)'s sort of now-famous quote about that was "Where people live ought not to determine if they live."

So, hopefully, this feels like a natural step to the experts on this committee. The concept of increasing population access to trauma care was invented by this community.

But, there is a disconnect, as you know, between the proportion of patients that could access trauma care and the proportion that do. And our hope is that a population-based framework for measuring outcomes creates a shared incentive within the health care community to improve cooperation across (the course).

So, our goal is a trauma system prepared for day-to-day injury events as well as for rare catastrophic events. As I said earlier, the regional disaster health care system is going to require a strong foundational trauma system to build upon to increase capabilities to make it an all-hazard system to think more

about high-consequence infectious disease, chemical and radiation injuries, burns and things of that nature.

And I guess in short I'm saying I hope this group can help us to build the bridge between the lofty nebulous goals of population health and the concrete, measurable metrics that gets used in assessing health care.

So, again, thanks to our – to the colleagues at NQF and certainly to the folks at CMS who have invited us to share some of our content (interest and our) subject matter expertise. And thanks especially to this group for coming together.

Christy Skipper: OK. Thank you, Brendan. So, now, I'll turn it over to Andrew just to give you all an introduction to NQF and the work that we do here.

Andrew Lyzenga: Thanks, Christy. So, yes, I know some of you have worked with us before so are probably familiar with our work, but I know a number of you also have not. So, we'll try to give you a little bit of background on who we are and what we do.

NQF has been around for nearly two decades now. We are a non-profit, non-partisan, membership-based organization. We are funded by a variety of stakeholders, but primary the U.S. Congress through the Department of Health and Human Services.

Our responsibility is to bring together public and private sector organizations to reach consensus on how to measure quality in health care with the aim of making the nation's care better, safer and more affordable.

Now, we have about upwards of 400 organizational members, some pretty diverse membership. It includes hospitals, medical groups, health plans, physician societies, nursing organizations, purchases, patients and consumers, and a variety of other groups that have a sort of stake in the – in the health care system.

We have more the 800 expert volunteers who collaboration with us on this sort of committee annually. I really appreciate all of your work. It's very

critical to what we do. And as Christy mentioned earlier, everything we do is open to public participation. All our materials are accessible on our website. And we are very committed to doing our work in a public and transparent way.

And go ahead, Christy, to the next slide. So, we work under a three-part mission to improve the quality of American health care first, as I mentioned, building consensus on national priorities and goals for performance improvement and working in partnership to achieve them.

We were – you know, work together with the Department of Health and Human Services in developing the National Quality Strategy, which has sort of provided the foundation for a lot of the federal government's work on quality.

The second is to endorse national consensus standards for measuring and publicly reporting out performance and, then, promoting the attainment of national goals through education and outreach programs. We do this through a variety of different kinds of work. Christy, if you want to go to the next slide, I'll talk about that a little bit.

So, first, one of the – one part of our work is the performance measure endorsement process. This has historically been kind of core work. And it's what many of you may be familiar with if you've heard of NQF before. Through this process, we accept specific performance measures that are submitted to us for evaluation and review.

And we evaluate – we bring together committees of experts to evaluate those against a set of standardized criteria. We make sure that those measures are important to measure and report, that they are scientifically rigorous and, you know, reflect both reliable and valid data and reflections of quality.

We make sure that they are feasible for implementation, that they are usable and used in important programs and try to move the field towards sort of a parsimonious and streamlined set of performance measures through consideration of competing or related measures.

Another sort of line of work that we do is through the measure applications partnership. And with this work, we advise the federal government on selection of measures for specific federal programs, typically public reporting or payment programs, through CMS, health exchanges and other programs.

Again, we convene private and public sector organizations through that program to help provide input to the federal government on those programs and the measures that should be included therein.

We have some work through the national quality partners that is, in some ways, kind of on the sharper end of the stick. You might describe it as more quality improvement-focused. We put together – we convene stakeholders around critical health and health care topics and try to spur action on specific issues, patient safety.

We have done some work around antimicrobial stewardship, maternity care, patient and family-centered care, readmissions and other topics and try to put together materials and playbooks that can be used sort of on the ground to improve quality of care.

Finally, we have a set of broad – sort of broad set of projects that might be described as measurement science-related. And this is where we kind of provide guidance to the field on how to improve measurement as a whole.

We have done a number of different projects, for example, creating frameworks in – or conceptual frameworks for measurement in areas that are kind of more nascent and haven't really been developed yet and try to provide guidance to measure developers on how they should move forward in these – in these areas. And this project probably falls most under this category where we are trying to sort of spur the field forward, provide some broad guidance around the topic of trauma and measurement of trauma outcomes, again, at a population level.

So, we are not, as we do with the endorsement work, evaluating specific measures at this point but, rather, sort of taking a step back and looking at the topic. And we're generally – and trying to provide advice and guidance to the

field on how we can best move forward with measurement in this area in the future. So, I think that's all I've got. If anybody has any questions, happy to give you any answers to provide any more explanation.

Christy Skipper: OK. Thank you, Andrew. So, now, I'll just jump into an overview of the Trauma Outcomes Project. So, as you all know, trauma is a leading cause of emergency department visits and hospital admissions each year. But, in order to address and monitor the quality of care and reduce trauma-related mortality, we need a coordinated system of care and a way to determine if what we are doing is working. And if not, we need to learn from it and fix it.

The problem is that quality improvement efforts focus on individual providers or health systems, and it doesn't really take into account trauma patients who receive care from multiple providers and across multiple settings. So, in order to inform providers and consumers about the quality of care, a measurement framework is needed to adequately capture trauma outcomes.

So, this is where you all come in. We have been asked to convene a multi-stakeholder committee to guide and provide input and direction on the environments scans for measures and concepts related to trauma outcomes and to identify any measurement gaps.

We'll use that information to help inform the development of a measurement framework. And as Brendan shared with you earlier, we need to consider and discuss recommendations for developing and choosing attribution models.

We also need to discuss options for incorporating the concept of shared regional accountability into the framework and then, also, discuss and look at approaches to risk adjustment and the strengths and weaknesses of those approaches. And then, finally, we will take a written report to summarize all of our findings.

So, all of the measures and concepts that we identify in the scan will write up the measurement framework and all of your discussions and input over these next several Web meetings and in-person meetings.

So, this slide just shares the project timeline between now and May. So, following this Web meeting today, we have six additional Web meetings scheduled and one in-person meeting in Washington, D.C. I do want to point out here that we did change the date of the in-person meeting because the original date conflicted with the American College of Surgeons' meeting and we did not want to have you all, you know, choosing which meeting to attend.

So, we figured we move the date back. And, so, I do want to point that out that the meeting is now scheduled for October 15 and not October 22. And we still hope that you all will be able to join us for that in-person meeting.

We do have two deliverables, as I've said, the Final Environmental Scan Report – so, that report will be really a measure inventory of what we find over the next few months – and, then, a Final Report summarizing the scan, the measurement framework and the committee's discussions.

I mentioned earlier that we always provide an opportunity for the members and the public to provide input on the work that we are doing. So, there will come a time when the reports will be posted for a 30-day comment period where, again, members and the public can give us their feedback on the work that we've done. And we'll convene for a Web meeting just to review those comments and make any adjustments to the framework or any other additions or recommendations for the reports.

I believe I've sent all these Outlook invitations to your calendars. If there are other individuals, assistants and anyone else that helps you manage your calendar, please send their contact information to me or to the Trauma Outcomes inbox, and I'll be sure to include them on the invitation. I just want to go over – before I move on, I want to stop to hear if there are any questions about anything that we said so far this morning or this afternoon.

Avery Nathens: This is Avery. I just have one request. I wondered if you could forward to the committee an example of a previously-published report so we have a sense of the report structure and format.

Christy Skipper: Yes.

Avery Nathens: It's good to know what it looks like so we can target appropriately.

Christy Skipper: Yes. We can certainly do that. It's a good idea.

Male: I was wondering if these calls are being recorded and could be listened to later.

Christy Skipper: Yes, they are being recorded and they are available to be listened to at a later date. Yes. OK. So, just jumping into the roles of the committee. So, (we've seated you) to serve as experts to work with us to achieve the goals of this project. And with all of our meetings, we'll just ask you to review any materials ahead of time and participate in those meetings.

And as I said, you'll be helping us with our environmental scans – so, submitting additional keywords or if you know of any measures in use or measure concept related to trauma that we need to include in our work, please send those to us. And you'll also be helping us identify measurement gaps, developing – and developing the framework and providing input on the scan and the final report.

OK. NQF staff will working with you organizing all staff meetings and conference calls and will be maintaining communications between committee members, answering questions about the project that come in from members and the public and will be maintaining documentation of all project activities and materials and then, finally, publishing the final report for this project.

Now, I just want to point out and just emphasize that we are conduction environmental scans of measures. This measure – or this project is not meant to promote any one measure that we find over another. And we are not trying to endorse any measures in this project.

It is a framework project. We are taking a snapshot of the measures and concepts that we find over the next couple of weeks and months. So, we are not trying to find every single one. It's just sort of a – like I said, a snapshot in time.

And these just are a couple of the questions that we have drafted to guide our research. I won't read them word for word here. But, I (inaudible) for a moment and let you take a look at it. And let us know if there are additional questions.

I'm sorry. Someone is not on mute. If you could mute your phone, please. Yes. So, these are just some of the questions that we have used initially to guide our work. And I will now turn it over to Jean-Luc just to give an overview of the environmental scan.

Jean-Luc Tilly: Great. Yes. As both Andrew and Christy have pointed out, the environmental scan, the – you know, the goal there is really to identify as many measures and measure concepts that are out there as we can but then, also, you know, look to existing publications and into the grey literature and government publications and what other non-profits are working on articles published in – through the journals as well, you know, to kind of get an idea of what the field is – what the consensus in the field is about the gaps in measurement, you know, where we want to – where we haven't found existing measures or have (inaudible) measure concepts but where we think that there is an area that's right for measurement and that we can suggest the concept of our own. And that's really our contribution to the literature there.

So, for the purposes of this project, we are defining trauma. This is the definition from the American Trauma Association. It's a severe blunt, blast or penetrating injury primarily caused by automobile crashes, gunshots, knife wounds, falls, battery, burns – or burns and ranges in severity from very mild to, you know, severe life and limb threats. So, it's a pretty broad definition of physical trauma but excluding specifically psychological trauma or the kinds of secondary trauma like compassion fatigue.

So, the way we are thinking of a – of a measure is …

Male: I'm sorry. Can I interrupt for one second?

Jean-Luc Tilly: (By all means).

Male: So, would PTSD be considered in that or not?

Jean-Luc Tilly: I'm sorry. I didn't hear that acronym. Could you – could you repeat?

Male: Would PTSD be considered included or not?

Male: My understanding here is that PTSD would not get you into the measurement framework. But, PTSD might very well be an outcome worth measuring.

Jean-Luc Tilly: That's right.

Male: OK. Thank you. Thank you.

Jean-Luc Tilly: But, you know, certainly the definition we've selected for the time being – if there is a strong feeling (or one reason or another) that we need to look back at that, you know, as part of our deliberation if we can – we can definitely think about that. Thank you for your question.

So, we're defining a measure as an assessment tool or other calculation method that aggregates data to assess the structure, processes or outcomes of care within and between entities. So, you know, generally, when we are really always – when we're thinking of measures, they have a numerator and a denominator and exclusions (to say that's looking to see that a rate of some kind in which a thing happened, you know, a thing being on the structure or process or outcome of care).

A measure concept – (usually, of course), very often when you're thinking of measuring one of these structures, processes or outcomes you might find that you don't have a fully-specified measure as yet and you have a kind of target population and some idea of what the numerator would look like but haven't finalized the exclusions or otherwise specified all the details of the denominator or the logic of calculation.

Those kind of more preliminary measures – those more preliminary measures (inaudible). So, these are more potential (inaudible) that could be used that we'll also want to classify as part of our environmental scan.

So, again, you know, kind of imagining our trauma definition, we are – we are looking – or we are selecting search terms to be pretty broad in terms of the

kinds of physical trauma we are – we are interested in and kind of combining those terms with terms that would identify performance measures – so, terms like "measure," "survey" and "scale" and so forth. So, I may well just leave this up for a couple of seconds.

And, of course, these search terms are where – you know, one of the primary ways we are looking for your input as the committee and to be – to how we are going about the environment scan. You know, if you see terms that – terms that are missing, of course, let us know. But, if there are terms in terms in there that might lead to misleading findings for one reason or another, also let us know. You know, maybe there are terms that are out in the field that we aren't aware of.

Female: Will each of these particular terms have a very specific definition to accompany them?

Jean-Luc Tilly: No. These are either terms that we'll be using like as part of our searches. But, we weren't planning to arrive at a formal definition of these.

Female: OK. Very good. Thank you.

Jean-Luc Tilly: All right. And, so, you know, our expectation, of course – I mean, the reason that we are convened to do this project in the first place is that, you know, there aren't very many performance measures out there. We understand that. We are prepared for that.

So, our goal is to supplement the environmental scan with key informant interviews, which is to say, you know, in addition to the broad range of expertise that we have convened here on this call, we want to take an opportunity to get in touch with a few different people – of course, a few individuals that you suggest. But, we have a few individuals in mind as well.

And a list of candidates will be circulated to you at some point as part of the environmental scan process. And, so, we'll reach out to them to – you know, to, you know, maybe if there are specific pieces of literature that we want to hold on, we would ask them about and the application of that in their own

experience or else to look for suggestions for new measure concepts or otherwise elaborate on measure gaps.

Christy Skipper: Thank you, Jean-Luc. So, I just wanted to turn it all – this is over back to the committee just if there are any questions for us about the project or any reactions or responses to our search terms or guiding research questions or anything else that you all would like to discuss or have answered now. We have given some time in the agenda for that.

So, are there any questions for us? Or have we done a pretty good job explaining, you know, what we'll be doing over the next few months? It sounds like we have. But, I will start to move on. But, please feel free to interrupt me if there are questions that come up.

Avery Nathens: Yes. Before you do – it's Avery again. Those search terms for the environmental scan – they probably have to be – I think we need some additional terms in there to combine with these terms. How do you want that sort of feedback?

Christy Skipper: You can send us an e-mail at trauma@qualityforum.org. And I check that e-mail every day and – well, you need to send that by e-mail and we'll get that.

Avery Nathens: OK.

Male: And forgive me I'm not in front of my computer. Do you have the current listing available in the materials?

Christy Skipper: It's on our slide deck. And the slides are available on the – on the public webpage. So, you can log in to that later and look at those. And it's slide number …

Male: OK.

Christy Skipper: And it's slide number 21.

Male: OK. Thank you.

Christy Skipper: OK. And I'm glad that you asked that question because now I'm going to transition into our SharePoint site, which is where we house all of our project documents. So, you all should have received an e-mail with your log-in information, log-in name and password.

Once you navigate to this site, you will come to the trauma outcomes page. And on it, you will see a copy of the roster. Here on the left-hand side, there is a link to the committee calendar, any committee links that we think are important. You can click on the Committee Roster button, again, just to see who else is on the committee and get their e-mail addresses. And then, also, if you click on Staff Contacts, all of our project information is there as well.

And, then, towards the bottom of the page, under Meeting Documents, we posted the slides for today as well as the agenda. And we will do that moving forward for each of our Web meetings. So, you know, hold on to your log-in credentials because you can check this page at any time just to see what's going on in the project then, you know, take a sneak peek at our slides.

And so, really, all of – everything that we are doing is going to be housed on this page. And, so, you will be able to access it easily. And I just want to remind you all that if there is an assistant that you would like to have added to the distribution list, please also send that to trauma@qualityforum.org. OK. And, so, if there aren't any questions – I'll pause just to hear if there are questions.

James Eubanks: Hey, Christy. This is Trey Eubanks in Memphis. How broad do these terms need to be? For example, I didn't see anything there about air transport. Would that be (something) that we would want to consider adding? And if we have a suggestion, should we just e-mail those to you, or do we need to discuss those as a committee?

Christy Skipper: You can definitely e-mail them to us. And, you know, air transport definitely would be a term that we would want to include there. So, nothing is to broad – I don't believe. And, again, yes, you could just send us an e-mail.

James Eubanks: OK. Thank you.

Christy Skipper: OK. Thank you. All right. So, I just want to move to public comment. Operator, can you open the lines to hear if there are any questions or comments on the line?

Operator: Yes, ma'am. At this time, if you would like to make a comment, please press star, then the number one.

And at this time, there are no public comments.

Christy Skipper: OK. Thank you. So, just next steps for our project. This meeting today was an orientation, just an introduction to the work that we will be doing. Our next Web Meeting on September 11, we will be taking a closer look at our preliminary environmental scan findings. And we will just dig a little bit deeper into the measures and concepts that we found and ask for your input that way.

So, that meeting is scheduled for September 11 from 1:00 to 3:00 p.m. Eastern. And we look forward to talking to you all then. But, before I close, I just want to give one more chance for any questions for us. If not, we'll adjourn.

All right. And this slide just shows our e-mail address, our phone number and how you can access the project pages. There is a project page and then that SharePoint page where you will need your log-in credentials.

All right. So, it looks like you all have an hour back into you afternoon. We thank you, all, for joining the orientation call this afternoon. And we look forward to working with you all. Thank you and have a good afternoon.

Male: Thanks.

Male: Thank you.

Male: Thank you.

Male: Thank you. Nice job. I appreciate it.

Male: Thank you. Good job.

Male: Thank you.

Male: Thank you.

Male: Thank you.

END