NATIONAL QUALITY FORUM

Moderator: Sheila Crawford
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05:00 pm CT

Woman 1: ... and sort of I have to quickly go over the guiding principles in the framework and with that I'm going to turn it over to NQF to get started.

(Dajani Muckerjee): Yes, so, (Nadia)?

(Nadia Kumar): Sure, thank you, (Dajani). This is (Nadia Kumar), the Product Analyst on the Healthcare Readiness. With me is the NQF (Dajani Muckerjee); the Senior Director, (Panab Baba), the Senior Product Manager, and Project Manager, (Jesse Pines); our consultant, and myself. And we'll begin today with the roll call. Okay (Paul) I know you're here, (Scott Aaronson).

(Scott Aaronson): I am here.

(Nadia Kumar): (Joanne Bell)?

(Joanne Bell): I'm here.

(Nadia Kumar): (Emily Carrier)? (Cowan Kase)?

(Cowan Kase): Here.

(Nadia Kumar): (Barbara Citarella)?

(Barbara Citarella): Here.

(Nadia Kumar): (Caitlyn Durvey)?

(Caitlyn Durvey): Here.

(Nadia Kumar): (Alexander Garza)? (Jennifer Greene)? (Angela Hewitt)? Was that you, (Jennifer)?

(Jennifer Greene): Yes. I'm sorry about that.

(Nadia Kumar): No worries. (Angela Hewitt)?

(Angela Hewitt): Yes, I'm here.

(Nadia Kumar): Okay. (Sagla) is not able to join us today. (Mark Garrett)?

(Mark Garrett): I'm here.

(Nadia Kumar): (June Hill)?

(June Hill): I am here.

(Nadia Kumar): (Matthew Knott)?

(Matthew Knott): I am here.

(Nadia Kumar): (Unintelligible)?

Woman: I'm here.

(Nadia Kumar): (Steven Cruz)?

(Steven Cruz): I'm here.

(Nadia Kumar): (Nicolette Loucit)? Okay, (David Marcozzi)? (Juan May)? (James Poturez)?

(James Poturez): Here.

(Nadia Kumar): (Patrick Reilly)? (Martcie Ross)?

Woman 1: (Marcie) is here. She's just - she's on the ...

(Nadia Kumar): Okay.

Woman 1: ... she's a little bit sick right now.

(Nadia Kumar): (Lucy Savet)?

(Lucy Savet): Here.

(Nadia Kumar): Than you and (Dave Taylor)?

(Dave Taylor): Here.

(Nadia Kumar): Perfect. Just to note, (Margaret Weston) is currently held up at the airport so she will unfortunately not be joining us today.

Woman 1: Just another round to see if anyone - who just joined us, if you could let us know you're on for committee members.

(Nadia Kumar): Okay, thank you, and we will continue to go to the…

((Crosstalk))

Woman 1: So, again, just to recap our scope, remember, is to focus on the quality measurement of healthcare delivery, again, by the healthcare system prior to, during, and after an emergency or disaster. This framework is - serve as a conceptual type of framework and - for future development of measures and as well to facilitate any prioritization of measures and/or measurements.

Our objective for today as (Dajani) had said is really just to finalize all our domains, sub domains, and measure concepts prior to (unintelligible). So I'll turn it over now to (Panab) to start us off.

(Panab Baba): Okay, thank you so much and just a reminder to everyone, please mute your lines. We give you the lines open but we ask that you mute them unless you're speaking. This will help us with not having background noise. Additionally, using the features on the software, if you would like to make a comment and be part of the discussion, please make sure to raise your hand as we go through and then (Paul), as our co-chair, will call on you to guide the discussion.

And then also feel free to chat anything in the chat box that you think may be along the lines of, "Oh, I agree with that person," or, "Here something

additional to know," if you don't really feel like (anything in) them or if you're unable to announce it on the call and just want to make sure that at some point is said, we can make sure to read it out for you.

So just - the - some of just housekeeping. So as (May) said the goal today is to really finalize the domain, sub domains, and measure concepts along with that we'll also be finalizing the guiding principles. We have talked about this many times over our other webinars, but it's important that now that we've had a concrete report written, that everyone is on consensus on what we're moving forward with.

We know that we've talked about the guiding principles many times and verbally described what we're hoping to achieve with them, but I've never actually sent out the written version until the most recent version. So, hopefully, all of you had a chance to look over the report. We know it's a little lengthy, but hopefully no shockers or surprises there.

So starting with the next slide please, so we just wanted to quickly just remind you of the guiding principle. We did divide them into three subcategories of what, the where, and the how. The guiding principle that we move forward with was person-centered capacity and capability-focused, availability and inaccessibility, maintenance of health under what, care beyond hospitals, scalability, (GR) full considerations, healthcare size considerations under the where, and then communication amongst - among entities, preparing for that known and unknown, means of preparedness, and post event measurement in the how.

And so at this point we're not really looking to, you know, (Wordsmith) but we want to make sure that the guiding principles match your understanding of those, and that we've captured the discussion well, so next slide, please. So

our question is exactly that and I'll give it to (Paul) so lead the discussion. But if you have any comments about the descriptions or anything that you would like to say about that, please make sure to raise your hand. (Paul), did you want to start with anything while we get people to get their hands raised?

(Paul): Sure. I just - I want to say, you know, thank you so much to the NQF staff for all of the work done to date. I think we've come a very long way since the beginning of the project and certainly I'm really eager to hear people's thoughts and comments as part of the discussion today before this goes up for public comment. So (Steven), I see you that you have a hand raised.

(Steven Cruz): Yes. Actually, could you just go back to the prior slide to sort of refresh my memory, there we go. Thank you. Just a couple of random thoughts. First of all in terms of the what, do we want to look at impact for communities so it's just not the person, but it's the community, because that's the problem with the greater good and disaster response? And then, secondly, since this report is - some part about metrics, the only thing I see in here on measurement is post-event measurement and I think what we're trying to construct here is something that would allow ongoing measurement in preparation and in mitigation. And, again, I think that the necessity for metrics and how they would actually help to drive the system and its improvement I think are really quite important. Thanks.

(Paul): Yes. I think those are definitely great comments. I think, you know, certainly as you've said, this - in - this whole project is definitely meant to be about measurement. And so we need to make sure that's captured well within the document and I don't know how you feel or how the others feel. I think, you know, in many ways the concept of post-event measurement is making sure, as you've said, lessons are learned and captured from all the data that are developed and all the measures and metrics that are utilized.

And so maybe - that may be one word that, you know, we change to or one principle we change the phrasing of to capture the concept of, you know, accurate assessment and learning from the lessons, and the evidence, and the measures, that we have, you know, after each - either exercise or event. Does that make sense?

(Panab Baba): Yes. (Paul), this is (Panab) with NQF I completely agree, I think. That's what the ongoing measurement with what we were trying to achieve with that one and - but I think it's - we need to make sure we make it clear. So that was a great point. Thank you.

(Paul): Perfect. Yes, thank you very much and (Mark), you have your hand raised.

(Mark Garrett): Yes, I would follow up on the same thing and perhaps just making overarching or introduced under the guiding principles rather than doing it for each thing just say the why and the why is, you know, the why is the need to measure preparedness or something like that. So that would go to all three categories, because we need, you know, we need to be able to measure, you know, even have definitions for size, care, beyond - I mean, scalability.

I mean, I think all of these things are going to be measured, so I would just generalize it, maybe have a column down on the right just saying why that goes across all three, why measure, you know, to have an appropriate metrics or whatever.

(Paul): Yes, I like that. I think, you know, definitely talking about the why is so important. Obviously, I think you're exactly right that the why of this whole project is to, you know, measure preparedness both as - so we know where we are now and where we need to improve, so I like that a lot, see what we can do

to incorporate that. Any other comments, they were both very helpful suggestions.

Excellent. All right. So we will move forward now into the framework and again, you know, what's been done so far is - has been meant to incorporate all of the phenomenal discussions and the input, and the feedback from the committee members that have been gathered to date. And remember that the framework is meant to encompass all of the phases of the emergency preparedness cycle and it's meant to be iterative that there is - it's actually, you know, sort of nicely raised in the comment of thea post event measurement that there's ongoing quality improvement. There's ongoing feedback. There's ongoing reassessment.

And so, you know, single static measures are not nearly as helpful in concept as iterative measures where we can document progress and improvement in the system. Within the framework, as I think everybody has seen in the document, the framework has been structured around the four basic Ss of staff structure, and system, and so sort of the basic organizing principle of the framework with those four domains. And then each of the four domains has been divided into sub domains.

The sub domains have been edited somewhat and we tried to intercept, we tried really hard to incorporate everybody's comments and feedback in both the actual specific commentary of the event, but I think there's also a lot of spirit of the commentary to make sure the things were included or added. So what we would like to do is make sure that we can come to a consensus on the sub domains and so to go through them we would really like to make sure that you have a chance now to comment on where you think the goods do capture, the concepts capture what has been discussed so far if there's anything that's missing.

You definitely would like to especially know if you think there any gaps remaining. One of the important concerns is that, you know, the framework needs to be comprehensive that there needs to be a home for the future measures of preparedness as additional measures and metrics are developed. And so if we have then the sub domains under the domain, there's a gap remaining, now would definitely be a good time to mention that.

So if you can see here on the slides, we have retained the same domains that everyone has seen of staff structure, I'm sorry, staff structure and systems. And then sub domains have been rewarded a little bit to fit both, I think, with the previous comments on the different committee calls that we've had as well as to sort of be a little more consistent a little more parallel, some - you know, build some logical consistency with them.

So for staff, obviously, we have staff safety, capability, sufficiency, training, and support. I won't read this whole slide to you, but staff we've divided into - splitting pharmaceuticals out separately from durable and consumable supplies and then - although I recognize that non-medical supplies can be just a huge group of supplies that are essential for the delivery of care ranging from, you know, fuel oil to food. We need a home for all of them without having, you know, 20 or 30 different sub domains and so I wanted to make sure that still makes sense to everybody.

We broke down facility infrastructure into it what's existing and temporary and then thought about what was unique or special for certain types of hazards, scenarios or hazard response. And then, as we talked about in several of the committee meetings, the systems domain is big and broad and has many different aspects to it, but, you know, having effectiveness into the

management systems and emergency response systems is essential for the healthcare system to be able to deliver care in a disaster.

So, again, it got rephrased and organized a little bit differently, but I think I'll pause here and see if folks have any specific comments on the names of the sub domains or the way they're organized. And, (Mark), we'll start with you.

(Mark Garrett): Thanks. I probably had so much coffee today. So under staff, I don't know how to do it, maybe an asterisk for it. I think we also have to think about volunteer, okay, how are you going to handle volunteer safety, volunteer training, because in a major disaster we often have volunteers whether they're, you know, licensed providers who come from somewhere else or just, you know, volunteers to help staff a, you know, a off-site place for the (worried well) but help to direct people, et cetera. I think we have to have at least an asterisk to support that to say that people have prepared for how they're going to handle the volunteers.

(Paul): Yes, I like that comment and I think - but I just want to make sure - I want to see - that's something to see good reaction. I think absolutely there's been an intent with all of this to consider, you know, volunteer safety, volunteer capabilities, are they appropriate, volunteer sufficiency, you know, do we have enough or we - are we either over or under counting the number of volunteers that we may have, et cetera, you know, with training, just in time is necessary.

So everywhere, so staff certainly applies to volunteers, so the concept was that whether it's, you know, employed staff on a day to day basis or volunteers who may be used in a staff role that that's all encompassing. And if you can definitely edit the text within the document to include that, but would that be enough or do you think definitely - which is like a - sort of an extra asterisk, I

think that's interesting idea, just make sure it says staff, but we really need staff and volunteers.

(Mark Garrett): Yes, I would I would go with the asterisks just so people realize it's a separate issue, but it has to be included, that's all. I mean, you know, I think - I guess it's not kind of how it looks, so it doesn't look - so it meshes with everything else. But I think that's kind of important, so maybe just an asterisk next to staff and then on the bottom say applies to volunteers and where appropriate applies to volunteers as well.

(Paul): Yes. Good. Yes, that's helpful. Thank you. (Steven)?

(Steven Cruz): I'm sorry. Can you guys hear me okay?

(Paul): Yes.

(Steven Cruz): Actually, (down) to systems. I've - I was, again, looking at it this morning. They're - I think they are two things that are - I don't know if they're necessarily missing, but I don't think that they have much of an emphasis as you can drill into the proposed measures. But one of them is patient transport and I think it's - that's probably more of a systems issue and I think it's certainly be rolled into any one of these sub domains, but in the current document it does not appear as such.

I think the other thing - I think I saw the word evacuation mentioned somewhere, but evacuation planning for that is not just an issue for hospitals but for a variety of other facilities in the healthcare system. And so I would encourage the consideration of both of those as sub domains.

(Paul): Thank you. Yes, I think on the evacuation side I think it's got components of an incident specific capability. I think you're exactly right that, you know, evacuation to health care facility whether it's an acute care facility or other, it is one of the most complex and dangerous disaster response for an organization there is. And so definitely worth considering, you know, how it best fits into the system, but I completely agree with that.

For transport, I think, I'd like to see what others think as well. I think transport is really hard to know exactly how it best fits into here but I do completely agree how important it is and we've talked about, you know, the importance of not just, you know, a transport asset but the right capabilities within that transport asset that meet the needs, you know, whether it's a neonatal patient or complex pediatric or a, you know, person with mobility difficulties that doesn't necessarily did a lot of acute medical care.

You could consider it a staff of sort, but it doesn't really fit within the sub domains here. I don't - are there other - anyone else that wants to comment on the, you know, how or where we might - we want to make sure that transportation measure concepts and measure fit within this list.

(Jesse Pines): Yes, this is (Jesse) here. So I think, you know, some of the concepts that have already been mentioned are included, you know, not as sort of - this - at the sub domain level, but more at the measure concept level. So, for example, you know, we do have some measures that do include volunteers that we, you know, we do measure concepts that do address evacuation, it's just a question of whether or not we would necessarily need a separate sub domain for it.

You know the - for example I think for our evacuation measure concept, I think we only have one or a few. So I'm not sure we would necessarily need a

whole separate sub domain for that, but I think a lot of these are embedded in the consequence themselves.

(Paul): Yes, thank you, (Jesse). (Caitlyn), you have your hand raised.

(Caitlyn Durvey): Yes, I was going to say for the evacuation I was thinking in the scalability you talk a lot about scaling up, but that could go into scaling down as you are in kind of the recovery phase with assessing what you can do and what you can't do and what areas are usable in your hospital or healthcare facility. So that might be an area to kind of pull that in as well and that does relate to transport which is an issue of not necessarily like the nits and grits of the transport, but just making sure that there is a discussion of working with other entities to do that, which I think is encompassed within a lot of the discussion but isn't as pointed out specifically.

(Paul): OK, thank you. (Scott)?

(Scott Aaronson): Yes, I was just going to add to that on transportation that we could include something that - because I think getting into the very specifics of individual patient types could be extremely challenging and probably maybe going a little farther than necessary. But we could have a component in here where we identify that you have a mechanism in place for measuring the correct transportation based on your patient population and being able to match up right patient, not right place per se but right patient, right mechanism of transport and then contracts associated with that.

So I think that sometimes people aren't thinking through what's necessary for movement of their patients and again if you keep it generic enough, we can address it from the population, the community side as well as into the larger academic medical centers.

(Paul): Yes, thank you very much. (June)?

(June Hill): Yes, I just - again, parallel to transportation, our - I didn't see the concept anywhere and I'm not done reading it all yet, but - like safety checks, health and wellness checks, in terms of (we've seen_ a huge number of people who are living independently in the community with chronic conditions who may need something quickly or acutely, but may not necessarily need to get to, you know, a facility but people might need to get to them. So just not augment - complement to transportation, so - I didn't quite see it anywhere, so just to add that.

(Paul): Yes, thank you. I think, you know, within and I know - you know, different healthcare systems approach this differently, but, you know, within the frames of, you know, healthcare systems exactly you say performing wellness - these wellness checks on, you know, certain patients or clients that they're affiliated with. You should definitely think about how that lives within the system's domain in terms of, you know, potentially some of might be a communication asset or communications capability, but you know they fit within other aspects of the system sub domains, so that was helpful. Thank you.

(June Hill): Yes, I do think we underplay the numbers of people who are needing support but are - you know, or can't get to you, so thank you.

(Paul): Yes, absolutely. Thank you. (Angela)? (Angela), are you on mute by any chance?

(Angela Hewitt): Hello?

(Paul): (Angela), yes. There you are.

(Angela Hewitt): Yes, I'm sorry about that. Yes, actually my call keeps dropping. Yes, (unintelligible) have a second.

(Paul): Yes.

(Angela Hewitt): Hello? Okay. I am sorry about that. I just wanted to kind of speak up in support of the transportation addition and that, you know, I can speak from a (bio) preparedness standpoint and that when we like took care of (unintelligible) at the hospital both the transport, you know, from, you know, these patients were - they're medically evacuated to our facility.

And so both the transport go from, say, the airport to our facility, you know, we had to work closely with (EMS). You know, it was actually quite the show and I think that, you know, that along with sort of the search capacity that's already mentioned, thinking about, you know, where are - how are you going to transport these patients. And if these patients are infectious, are they going to be transported, you know, via helicopters, is this going to be plane or is this going to be ground and that sort of thing.

So we've actually done quite a bit of investigation to that and as, you know, like our search capacity and identifying how we would transport these types of patients to, you know, various facilities in the area. So just something to think about. I think that actually would be a nice addition to the system list, thank you.

(Paul): Yes, thank you very much, (Angela). I think that makes - that definite makes good sense. All right, any other common thoughts before we move on to the measure concepts?

Okay. So, again, I think, you know, we'll take all of those thoughts and input which was very, very helpful in - back to the NQF staff. And then, what we'll talk about next is within each of the sub domains our individual measure concepts. So remember, again, within this framework that a measure concept is not an actual measure or metric, but a concept of what is to be measured. So, oops, I'm sorry. That's one more slide here.

What we would like to do with the group now is to come - to consensus if possible on the measure concepts underneath each sub domain. So we want to make sure that the measure concepts as they're listed are accurately represented of the discussions that the committee's had so far. And, you know, ideally make sure that there are enough measure concepts for the sub domains, try and make sure that people don't think either things are missing or get your feedback on where the wording may need to be edited.

You know, so it's - one example, you know, or the measure concepts around just-in-time training for staff training sufficient - we did have a lot of discussion during the committee members, the committee discussions previously about how important system time training is and so when we do get to that measure concept we want to ask people to very specifically give us some input on that.

And then for the last bullet there you can see on the slide, there are a couple of sub domains with relatively few measure concepts or specific measures listed. And against their individual measures they've been called from a literature view that was done at the beginning of the project. If we're thin on measure concepts in this area, we very much would like you to give us some feedback on where and how you think we might need to develop measures, measure concepts, excuse me, within the sub domains.

You know, the feedback we've heard so far from some of the committee discussions that these things are important, you know, staff capability as an example is, you know, are the staff actually capable of functioning within the rules that are assigned to them and how do you assure that that's the case. We definitely touched on crisis standards of care during several previous conversations and so how do we know that the plans and systems are in place, how do you measure rather the plans and systems that are in place to support crisis standards of care appropriate.

So we'd like for you to weigh in on those areas where that - the measure concepts are a little thin so that we make sure we've captured - we capture your discussions and your thoughts correctly. So if we move forward to this to the staff measure concepts to say everyone have the document open in front of them, the framework, so we can start going through them individually or does people need a couple seconds to begin to pull those up in the appendix.

So what I'll do - and it may take me just a second to get back and forth to post comments, but I, myself, have to toggle between the two documents. But for staff safety, we have several different measure concepts across the phases of mitigation preparedness response and recovery. Any comments on the measure concept listed for staff safety?

Woman: Hey, (Paul), we're just going to bring up as much as we can on the screen, so people can see it. It might be a little delayed, but hopefully people can see on their screen as well.

(Paul): Perfect. Thank you for that. (Scott)?

(Scott Aaronson): Yes. I was just trying to get clarification on one. So in the very first one under preparedness measure concept staff and volunteer security plan develop

that includes disaster planning. I'm not totally sure the intent of that to make sure that it makes sense, so if I'm on the provider side, I'm not sure exactly what we want. I could see the staff and volunteer security plan developed, but then to include disaster planning, I think there are - it may be redundancy in there.

(Boone): Hi, this is (Boone) from NQF. The idea behind that with that - the security plan considered disaster planning, so it wasn't just for day-to-day activity. It also considered what would be the needs during the disaster, which might be - it might be the same thing if we went there to be (unintelligible) consideration.

(Paul): So if we phrase it maybe as, you know, existing staff and volunteer security plans include consideration for disaster, would that also capture what the thought is?

(Boone): Yes, that'd be perfect. We can change that language.

(Scott Aaronson): Great.

(Paul): That sounds good. (Scott), does that make sense?

(Scott Aaronson): Yes, that make sense.

(Paul): Perfect. (Mark)?

(Mark Garrett): Yes. Hi. Just as a concept, as a general concept, because we have watchamacall, things we're measuring during recovery, but do we want a concept for the mitigation preparedness and a response that it actually occurred the way we have prepared for it. I mean, I know we do a lot of that in the hot wash, but do we want some conceptual basis that during the

recovery measure, we look back at what we mitigated or we prepared for and was it adequate? So I don't know how to do that, make a measure for them, I'm not saying we should make a measure for everything, but we may want that concept there.

(Paul): Okay. So something along the lines of - is a recovery measure concept within staff safety something of, you know, review of the effectiveness or documentation of the effectiveness of existing mitigation measures, something like that.

(Mark Garrett): Yes. Yes. I mean, we do it in the hot wash after an emergency but I think, you know, it's almost like a point score. Did, you know, did you prepare the right way, did you do this, not just like a little thing like we didn't, you know, fill the area up on the tires of the ambulance is enough, but just more about were our plan is correct. Again, as a retrospective guy to back so that you can actually improve it for the next time.

(Paul): Perfect, okay. Excellent. (Steven)?

(Steven Cruz): Hey, I just have a few ideas regarding the staffs for sub domain. First of all under - and I don't know if this is safety capability or training, but particularly for high consequent - high consequence agents, I think there needs to be something strong in here about the - not just the training of staff but also the monitoring of staff who are donning, doffing, and wearing a high consequence PPE. It's a safety mechanism for the staff, the safety mechanisms for all of the other people in the facility. And, again, I think it's sufficiently important that it ought to be called out.

One other point up, you - we have essentially one row here for capabilities and I know that later on in trainings, staff training there's a mention about

considerations for all populations in terms of training but should we be evaluating staff capability and caring not just for all populations but for patients who have disease or illness severity greater than what they typically care for, because that would be part of that institution's surge plan. So I think we could probably provide something more specific than this one row which is actually pretty big under capabilities.

(Paul): Yes, I definitely think that's helpful. I think certainly under staff safety as a response measure concept, I think, you know, monitoring of staff in either high stressor or high risk situations such as using, you know, unusual PPE makes sense as a measure concept there. And then I think similarly, you know, under capability, monitoring of staff performance in clinical duties, you know, outside of standard clinical duties whether it's higher acuity or just, you know, different anyway an adult taking care of a pediatric patient or vice versa. You know, making sure not just that - the just-in-time training was there, but making sure that there's a system to monitor the quality of care being delivered. This is ongoing monitoring, I think is a good analog, I think that's helpful.

(Steven Cruz): Yes. And actually just related to that, it means also about providing them with the resources that they need, so how are we - how are you providing them the expertise that they need to the point of care, so that's - I think that's an important consideration for facilities.

(Paul): Yes. I like that. Let me ask, do you think that's - these both more of a preparedness measure concept or response. In other words, did the plan, did the system anticipate the resources they would need to function in that environment and then, you know, are we monitoring the adequacy of that or do you think that - for both of those, this sort of equipment resources, expertise belong in both the preparedness and response the way it is.

Man: You know, it's one of those cross-cutting things and I don't know whether it's better to split or lump, but I think it certainly relates to staff capabilities and it certainly relates to systems planning. You're absolutely correct.

(Paul): Other thoughts either on safety or capability? Okay. We'll move into staff sufficiency. So, obviously, the thought of this sub domain is are there enough staff and are there plans in place to ensure there are sufficient numbers of trained staff and to an earlier point, there are some volunteer measure concepts here within staff sufficiency as well. Any thoughts on staffs efficiency, any comments? (June)?

(June Hill): Yes. Yes, under credential test sufficiency, should not the mechanism in place to credential - be part of their preparedness box, like how are you going to do it, you know, that need to be - it seems like - I kept playing (unintelligible) place.

(Paul): You know, that they sense. Yes, it belongs in the preparedness column rather than in a response column. I think you're right about that.

(June Hill): And the other is percentage of off-duty staff present during disaster. I wasn't - well, what is HVA stand for?

(Paul): Oh, HVA on the previous one, Hazard Vulnerability Analysis.

(June Hill): Okay. Just (unintelligible) somewhere but ...

(Paul): Yes, I think it's across the page, you're right.

(June Hill): The percentage of off-duty staff present during disaster, that seemed a bit more like counting people instead of guidance about a standard of some kind of like - I can, you know, so I tell you it's 10% or 40%, but I'm just not sure that was good enough, if you know what I mean. And so that's - and then the other thing under sufficiency was under volunteers. Do there need to be (MOUs) or contacts in place so that, you know, the agreements are kind of there and, you know, it's - there are some mechanism to activate the agreement in terms of community organizations and still having it in place, so it's easier to activate?

(Paul): Yes. I think two good - two very good questions. Maybe - can I ask the NQF staff to comment on those measures of percent of off-duty staff present?

(Panab Baba): Yes. Maybe the idea was just to gauge how many off-duty members are present during the disaster mainly just to make sure that we have enough and how many were needed at the time. It may not be the best mechanism for determining that. I mean, they're not the most important thing we're focusing on and if that so we can definitely think of alternatives.

(Paul): Yes. I think, you know, if it's okay with the NQF folks, I think we'd, you know, love thoughts on how best to word that to again look at, you know, sort of the reload potential basically of how many staff were not currently working are able to come in to make sure that, you know, the continuing operations are well supported. But I think maybe there's an opportunity to improve the wording of how that measure concept looks.

So that's really good and then I think due to the other point of that, you know, contracted volunteer organizations I think it's a very interesting one. I, you know, I think many of the staffing arrangements that are made with volunteer groups is done sort of during the disaster in many circumstances. But I think

either way to try and make sure that when appropriate or when possible, there are specific convenience in place. We have different volunteer organizations even, you know, including, you know, communication, (PAM) operators, volunteer organizations not just clinical ones, but also that the planning is appropriate.

I think, you know, many of us have seen in the past that there are some discordant assumptions between, say, hospitals and medical reserve corps about where their response priorities lie or what, you know, how big the resources will be that may be supplying the hospitals. So you can think about how we might tweak the wording to go into that for staffs sufficiency and pre-planning in the preparedness phase for looking with volunteer organizations. That's helpful.

Other thoughts on sufficiency? And then training is the next domain, so there's a lot in training about, you know, in all four phases about training ahead of time, just in time training, assessment of training, hazard specific training. So can I ask if folks have thoughts or comments on the training sub-domain measure concept?

(Panab Baba): And while we're on training, we do want to focus on that middle part where we talk about the second line here and the third line in our mind goes to our just-in-time training aspects. We're hoping to answer the concerns about that. So if those two did not seem sufficient enough, please let us know. Maybe it's alteration of wording or if there's any more concept that we need, we want to make sure that we did capture that since it was mentioned many times and I think that (Scott) has a comment …

((Crosstalk))

(Scott Aaronson): Yes, I was going to add in a couple of things. So on that staff training, the third one down, the time from event start to fully trained, I just would - as an organization would struggle with where we want to go with it. I understand we want to address just in time, so the first one being, you know, getting into the - that we've tailored it based on the event and the second one being from the point of training until you're - I would assume competent in there.

So it's - we just - probably to modify the wording associated with it from the event start to fully trained staff. I'm not sure that will accomplish what we're trying to do. And my second one was just about the percentage of staff trained on the next page on the operations of temporary facilities in the past 12 months and I don't think that percentage would work for us because we're not going to be necessarily training everybody whereas other things we're training, you know, all - like the one above I'd recommend we change it instead of number of staff trained moving towards clinical staff even though we do have other staff associated with it.

But we're - when we're talking about operation of temporary facility, that's going to be a smaller number of a strike team that we'd want to have, that could go establish set up, and run. And so we might have to just either eliminate it or narrow it down, because the concept is good to make sure that people know how to run the operations. But it may not be one that we can focus on per se, percentage, on there.

(Paul): That's definitely - no, those are both helpful. Excellent comments, thank you. (Mark)?

(Mark Garrett): Yes. I know it's a nuance, but you ought to put in something in the staff training that accounts for staff turnover, especially for a lot of the training that's yearly so you may train them in January. But by October, you may, you

know - the end of the hurricane season, you may have trained - you know, in certain area you may have had a lot of staff turnover and have new people who haven't been trained and/or have no experience in that area. So just something about maybe accounting for turnover somewhere in this.

(Paul): Yes, it's a - that's a good point. Excellent. (June)?

(June Hill): Yes. I thought that the concept of fully trained might need to be (teased) a little bit in terms of, I'm not sure if there is such a thing, but maybe in terms of competencies and capacities and capabilities might be more accurate. And also the concept of incorporation of resiliency based courses, I don't know what that means. It seems kind of unclear, I could guess but I'm not sure what that is.

(Paul): Yes. So I think that's a - it's a really good point to try and create a crosswalk between staff capability and training. In the measure concept you mentioned that, you know, it can be percentage of capable staff responding because that sort of incorporates all of the previous measure concepts from the staff capability section. Can NQF can - do you want to talk about what you're looking at for the resiliency based courses?

(June Hill): Yes, these measures were, you know, sort of ideas that were given to us. You know, a lot of this came directly from - to the committee ideas. You know, the - you know, for the specific one I think that resiliency based - you know, resilience is obviously an important sort of piece of, you know, of preparedness. So I think that was the source of that, you know, what - you know, why it was specifically resiliency and not other factors, we could certainly make that change.

(Paul): Excellent. You know, if it's helpful we can - you know, please folks give us - you know, if you have - plus if you have additional (unintelligible) but, you know, I think this is kind of a kind of a combination of the concepts of the, you know, preparedness at home for home and family readiness as well as psychological resiliency as well as other sort of pre training or as it was mentioned, resilience education that contributes to the overall resilience of the staff.

So either now people want to make more comments on that or in the next day or two, if you have specific thoughts about how we might need to break it down like in the component parts or reword it we would love to hear that.

(June Hill): Thank you. This is (June Hill). The only other concept was that it's been shown, you know, healthcare it's so hard to get training time for kind of use of multiple methods with - it just groups out, it cycles through, it doesn't really end. It's incorporated into many other things, so it's not always seen as a separate endeavor, so - and it's constantly reinforced, it's not - now, you've got the frequency but, you know, you drip it. It's kind of a drip, drip, drip.

(Paul): Yes. Thank you. Excellent. And that actually - naturally that's a nice segue into our last staff sub domain which is the staff support and there are some measure concepts that touch an aspect of resiliency there with, again, preparedness at home. So as we wrap up the staff sub-domain, any - I'm sorry, the staff domain, the staff support sub domain, any last comments on staff support on any of the four phases? (Steven)?

(Steven Cruz): Yes. Just - all right, just to put another plug in for something relating to attention (care) to professional self care. I mean, there's considerations here for families and housing and whatnot. That's essential, but getting into the meat of the matter, making sure that your team members are bearing it well. I

don't have the solution to the problem, but that's probably something that institutions …

((Crosstalk))

(Paul): Yes. I like that. I think, again, maybe, you know, that's - if we break out with the - some of that resilience measure concept from before and some component parts, you know, could be training on self-care for staff that could exist in the - either in the mitigation or the planning phases. And then, actually, you know, if we harken back to the nice comment that was made before about monitoring, I think, you know, monitoring of staff during response for, you know, adequacy and self care or for, you know, psychological resilience, I think that may be something that we could add in into this matrix if you all thought that was appropriate.

(Steven Cruz): Yes, I think we could do that. You know, I think, you know, another potential way would be to specifically breakout self care and be more explicit about that under this current staff support. You know, so basically say that, you know, these are - you know, that being sort of one of the personal needs would be self care.

(Paul): Yes. Yes. No, I like that. And (Barbara) I see your comment in the chat about behavioral health for staff support. Do you think that should be included in self-care? It seems like - probably an external resource, so separately split out do you think, you know, we incorporate through - I'm sorry, we add that - this matrix of - as a separate measure concept?

(Barbara Citarella): Yes, I think it should be separate, because it's really important because different people react as we all know very differently under stress and we

have to be able to identify quickly and get them the support they need, so they don't end up being treated for post-traumatic stress, et cetera.

(Paul): Excellent. Yes, thank you very much. Okay. Any other comments or thoughts about this or anywhere within the staff domain, any of the sub domains on the measure concepts that are listed for staff? Okay. We'll move on to staff and so as I had said just a little bit ago, right now we've broken the staff domain into sub domains of pharmaceuticals, durable medical equipment, consumable medical equipment, and non-medical supplies, and, you know, I recognize that we had kind of a ranging conversation previously trying to both keep it comprehensive, but also keep it manageable.

So let's start with the pharmaceutical sub domain and the measure concepts that are there. (Mark), it looks like you have a comment.

(Mark Garrett): Yes. Just - you have down in the - on the bottom one on mitigation frequency of annual - having 100% of stored supplies with expertise verified annually. I think everybody in a hospital probably does it monthly, just simply because of the fact that expirations, you know, occur at any time. And I don't think annually really is going to meet the need - I would probably say on a monthly basis or to make sure that you don't have expired meds sitting there, getting whether it's an emergency or not. I think it's a (unintelligible) practice.

(Paul): Yes. No, it's - I definitely would agree with that. I think - do you think that it's worth sort of splitting it out both that is - either a mitigation or a preparedness concept, I'm not sure exactly which column it lives in, but both that there's an annual or a - still may be a monthly inventory, but also that they have a plan in place for rotation. I think, you know, best practices, everybody is trying to make sure the things that, you know, have a less than six month expiration date, get rotated back into supplies. So do you think we should

both amend the current measure concepts as they verify monthly, but also add additional preparedness concept that there's a specific plan in place for rotation?

(Mark Garrett): Yes, I think so and may even say annually just review the, you know, appropriateness of the - of what you store. So, you know, do you keep enough (PAM) there? Do you keep enough other things there? You know, so - you may want to do that on an annual basis and the rest of the meds on, you know, rotation and by best practices or whatever, you know, by regulatory requirements, et cetera.

(Paul): Yes. Actually, I like that a lot, just personally having gone through review of our - some of our cash products and having to remove and add some, I think that idea of review of the specific items in the inventory for appropriateness on an annual basis is a good idea. Any disagreement with that or any other comments on that idea?

Man: Yes, we can do that.

(Paul): Excellent. Any other comments on the measure concepts within pharmaceuticals? Okay. So now moving on to durable medical equipment, thoughts and comments on the measure concepts we have for durable medical equipment? Again, these are stretchers, medical monitors, and disposable things. In terms of building on the previous comments for pharmaceuticals, you know there's creation of an inventory list under the durable medical equipment, measure concept.

Does anybody have a comment on whether there should be, say, an annual review of the inventory list that, again, for both the appropriateness as well as for, you know, whether the inventory is adequate? Maybe I'll say it

differently, can I suggest that we amend the current measure concept to state annual review of the inventory list of needed supplies and locations and does anyone have a concern if we change that slightly? OK, it sounds reasonable. It sounds good. There's a - great, there's a question about power level, so power levels are the on-hand supplies. It's how much is stocked at a - given your storerooms, et cetera.

So I believe the question probably relates to either, you know, using this framework for, you know, estimated power level for a disaster. So how much supply do you expect to have on hand? Let me know if that's not helpful. (Barbara), you have a comment.

(Barbara Citarella): Yes. Going back to the durable medical equipment and I look forward to hearing the rest of the committee comments on this. We say we're going to create a list and we're going to know where it's located, but we're not saying whether we're testing it.

(Paul): Yes. It's a good point. So can you - can I ask you to expand upon that a little bit just - in what way testing (unintelligible) whether it works or whether the inventory levels are adequate or both of those or something else?

(Barbara Citarella): Both of those. Yes, is it - does it work? It's one thing to know where it is, but if it's not working or we haven't tested it or there's been a problem, it's not …

((Crosstalk))

(Paul): Oh, I see. Yes, I'm sorry, I misunderstood. Yes, I think - so maybe we have to factor in the - yes, you know, testing for the biomedical standard protocol

or, you know, poor hospital protocol to make sure that the equipment is functional and so I've misunderstood what you say.

(Barbara Citarella): Yes, it's unsafe and it meets the safety requirements.

(Paul): Yes. Yes, definitely. That makes good sense. You know, (Kansas) have the equipment. It has those turn on function. That makes perfect sense. Okay, in consumable, other questions for the consumable measure concept that are listed here? And, again, if people don't disagree, I'd like to suggest that for each of these inventory lists, we amend them rather than to say creation, but annual review and update of these inventory lists both again for appropriateness as well as for sufficiency.

(Jennifer), do you have a comment?

(Jennifer Greene): No. I'm just following where I can actually login not just do the phone.

(Paul): Oh, I'm sorry about that. All right, any other comments on consumables? All right, and then non-medical supplies, again, this is a very, very big category. Is it okay if I also pull the comment forward about annual verification of storage supplies that I think in general most standard inventory practices even for non-medical certainly for food but even through - for others would be more monthly? Is that correct or anybody have concerns about that? Okay.

((Crosstalk))

(Paul): Okay, excellent. Thank you. Any other comments or thoughts overall on the staff, anything within that domain?

Okay, all right moving on then to structure. The subdomains here again have to do with existing facilities, temporary facilities and then hazard specific facilities. So we'll start with existing facility infrastructure and the measure concepts for how we will think about measuring adequacy of existing facilities for divesture. (June)?

(June Hill): Yes, under assessment of areas prone to flooding I thought it was odd that we only mentioned flooding. I know there's been a lot of press around flooding but I think there's – it's more than flooding its – there's earthquakes, there's other geographic vulnerability. So I may just ask that you expand that a little bit. I mean flooding is quite common but, you know, it certainly goes beyond flooding.

(Paul): So that's a very good point. Let me if I may expend the question a little bit to folks. Several different healthcare organizations -- like my own included -- are actually moving not just into assessment of flooding as per existing flood maps but really assessment of the vulnerabilities of the physical campus based on climate change. That based on depending upon whether you're inland or a coastal facility but storm surge, river flooding, precipitation flooding but also heat stress, wind stress how all of these threats are changing.

And often, you know, the assessment is whether you've looked – or whether the measures excuse me could be whether you have looked at up to date climate change projections for how severe weather may affect your facility do folks have thoughts on we're first off broadening that to include other threats that are environmental threats such as seismic which obviously would not be climate change but the rest, wind, heat, cold precipitation, et cetera, and then assessment with respect to predicted climate change any concerns any discussion about that?

(Lucy): This is (Lucy). I'd broaden it definitely and in include especially fire and seismic.

(Paul): Great, yes certainly wildfires is a very important one for a good number of hospitals absolutely.

(Scott Aaronson): Hey (Paul), this is (Scott). Do you want to just give a quick share with people about the new building that Partners HealthCare is putting up because that building is being done for future. It's being built with, you know, looking at the 500 year floodplain and then being another, you know, 30 inches above or whatever the breakout was in there. But there's a resiliency being built into that new design and I didn't know if that would just be helpful for people to hear a few of the components done and why?

(Paul): Sure. Yes, I'll try to be brief because obviously don't want to sidetrack us but, you know, we – we're about to build a billion dollar new building for our hospital campus. And as (Scott) mentioned it - we've engaged engineers to look at climate change projections for 2070 to look at what sea level rise, what storm surge, what precipitation, what heat and wind, et cetera, could do or will do based on the best available science. And that they're all very, very scary projections but it's affected the building elevation, it's affected the wind - rating of the windows it's affected the youth planning lots of things.

And it also is actually affecting how we're building the buildings and its relation to the other campus to the rest of the campus meaning there a pretty big hospital with about 1000 beds. And we are looking at it is what we call a facility of refuge so that some of our or vulnerable buildings if we have a severe weather threat patients could be evacuated out of those buildings into the more resilient one temporarily while we recover and that would avoid having to have us evacuate during the disaster. So, you know, if anybody

wants to know more after, you know, this call at some other time I more than happy to speak to anyone who has an interest.

But certainly again I guess that's a concept I was trying to get out with, you know, is people if we want to create a measure concept of how people adequately looked at their existing facility infrastructure and its vulnerabilities. And I don't know, you know, there's really nothing here in the measure concepts about utilizing disaster preparedness concepts or assessment of vulnerabilities for new construction. But I don't know whether anyone has a comment about whether it's a little bit too far for us to include, you know, utilize disaster planning scenarios with new construction of healthcare facilities or not as something we could put into, you know, the mitigation column as an example.

(Scott Aaronson): Yes, I think that is a good component to incorporate in there because it's becoming more prevalent and we're seeing too many failures based on not looking at that even with new structures that would be a good addition to review.

(Paul): Thanks, other comments on existing? I think - yes so thank you for the previous ones. We'll definitely try and expand the areas prone to flooding to include all the existing or to identification and assessment of all the areas environmental hazards. (Scott)?

(Scott Aaronson): I had someone here looking at the – in the sections -- let me make sure I've got the right one here -- for power grid adequate for specific types of disaster. And really in the second part instead of regularly tested we should just have to require codes in there because it was already…

(Paul): Yes.

(Scott Aaronson): …the parameters on testing.

(Paul): Yes.

(Scott Aaronson): And under existing facility infrastructure about backup power range it's the fourth one down. I'm not sure how we're measuring – so everything is good up to a point where we're looking at how measuring about power impact during disaster restored quickly. We just would have to have some parameter for what's being looked at as to how quickly we want to see it restored? I mean those are all everything is dependent on the incident. So I'm not sure what we're trying to get to response measure in there if it's remaining up or if it's – or if we're looking at a timeline for getting it back up but either of those are difficult to determine.

Under the existing infrastructure for the testing of health information technology we should just include up time and downtime procedure. And we may have had that in some other area. And then same would be testing the inner facility and inner healthcare system communications about the testing of and then the backup processes because they need to have a backup for the failure of whatever that mechanism is.

(Paul): Yes, no that is - I think lots of good points in there. You know, for the emergency power question there are a number – there is significant regions of the country where the healthcare facility cooling systems are not on emergency power because they haven't had to be to date. But I think I again with global warming and temperature change that is changing and unfortunately, you know, we have seen some consequences of what happens when a healthcare facility loses cooling capability. So I don't know whether or not we want to expand that that's certainly beyond code in many places

about whether healthcare facilities can arrange at least for backup power if they lose cooling because the only other alternative in that circumstance in hot weather is evacuation that's one.

And then two is where it says backup power range I think it's a good point that, you know, there's a lot of nitty-gritty details that matter not just getting a big portable generator there, you know, with sufficient power but actually having the right electrical hookups that it's much, much harder to get the generator hooked up to a healthcare facility if the pre-wiring isn't done if some of the pre-work isn't done. And, you know, the acute care hospitals of course have to have backup emergency power but outpatient and freestanding centers don't necessarily.

So does anybody want to comment on, you know, we obviously we can't create a measure concept that I think is appropriate and is going to encompass few care facilities outpatient facilities others without being overly specific. But if we said something like, you know, appropriate arrangements to support backup power generation or acceptance of backup power are in place something like that. Does that sort of makes sense? (Jay), you have a comment.

(Jay): Yes, that the facilities can get an inspection for an assessment done through the Army Corps of Engineers. They'll actually come out and do an assessment on that. You'll (unintelligible) database stored with those facilities. And that type of hookups that they need, the size of generator they would need and that would - it's definitely a time saver. So those assessments can be done and contact maybe your emergency management agency or maybe your public health preparedness folks can coordinate that being accomplished. So that is I think measure to have one piece done right there alone is a huge time savings

in the event of an emergency where you need to get power brought in to a facility.

(Paul): Yes, no thank you very much. It's a great tool and definitely a great program. I completely agree with that. And I think, you know, as we think about flushing out the measure underneath the measure concept, you know, that could be the standard that could be used is, you know, have you had an appropriate, you know, Army Corps of Engineers assessment. So that - yes I like that a lot. Any other comments on backup power or overall infrastructure?

(Scott Aaronson): This is (Scott), just to finish one last one. And I think that's already covered but I do like the idea of having the, you know, Army Corps of Engineers or other assessment done. In the very first one if we just change the wording to infrastructure failure plans established and tested under preparedness measure concept that covers all components of any failure that could take place based on loss of electricity, loss of HVAC, loss of water, loss of sewage - loss of sewer anything like that. So I think that would because that's a common terminology used under joint commission and used under other regulatory elements in NFPA.

(Paul): Yes, perfect. That's very helpful. Thank you (Scott).

(Scott Aaronson): Sure.

(Paul): Okay, under temporary facilities, again temporary facilities could - can be quite widely varied. But, you know, these are anything from tents or other structures that would be used to deliver surge care, specialty care, alter, you know, alternate care sites include are included in this subdomain. You know, we only had one row right now of measure concepts. Are we missing any things or anything you'd like to add or amend?

And then we'll consider also having specific structures. So these - this can span the gamut from individual patients (decon) facilities outside a hospital or an emergency department, to large scale either deployable or fixed (decon) facilities, or biological care suites or rooms. And, you know, also can include sort of how care would be amended beyond existing airborne infection isolation rooms to either be expanded to new capabilities or walling off of clinical care units per infectious disease any concerns or any thoughts about the measure concepts listed here? All right, last call for anything within infrastructure. (Barbara)? (Barbara), are you on mute by chance? While we're waiting for (Barbara) go ahead (Steven).

(Steven Cruz): Yes hi. Sorry I'm going to sound like a broken record here. This is another potential location to introduce a better concept regarding facilitation as part of a facility assessment.

(Paul): And I'm sorry I missed the feed of that. Can you say that again?

(Steven Cruz): Just this section again it's a crosscutting issue so there are potential concepts in all the four domains. But this is another place where as one is doing a facility infrastructure assessment and also considering very specific considerations the plans made to address the evacuation of a facility I think are really very important.

(Paul): Got it, got it. No that definitely make sense. (Barbara), I definitely see your comments here about transportation and arranging appropriate transportation to temporary patient care locations. I think that's a really important point give you a chance in case the phone dropped are you there now? Anything else you want to add to that? All right we'll definitely make sure that, that

transportation theme gets rolled in. I'm sorry right now unfortunately we can't hear you but we've definitely got the point. (June), go ahead.

(June Hill): The temporary facility infrastructure I think concept of agreements and MOUs have to be there as well. And also the concept of more than one agreement because you need to incorporate facilities at different distances away from where you are I mean in case, you know, your first agreement goes down or the second one goes down you still have a third one which it's further away than the first two. So the concept of agreements and going three deep in these agreements so you've got something.

(Paul): Excellent, yes thank you very much. Any other comments on infrastructure? Okay, all right so moving on to systems. We have obviously a whole bunch of subdomains within systems. We have added the subdomain that wasn't originally part of the discussion but so much of what we talked about in the previous committee meetings had to do with actions or system level responsibilities that should be ascribed to an emergency management program including assessment of hazards, we've been touching on that a little bit now, exercising regularly, monitoring performance, measuring performance during response as well as collecting data and producing after action reports and improvement plans following the disaster. So at least you have a whole bunch of emergency management program measure concepts so it's kind of a fertile field. But could I ask if folks have thoughts on those that have been put into the emergency management program subdomain? (Scott)?

(Scott Aaronson): Sure. On the Hazard Vulnerability Assessments, the HVA, I see we have an element that put the word quarterly into there. And I just don't want us setting any parameters that affect again counter regulatory requirements and accreditation licensure requirements which are for annual.

(Paul): Yes, that's a good point because I actually I missed that, that they had been a typo. You know, the joint commission and the CMS requirement is as everybody knows is for annual. Can I ask NQF is there an additional thought behind that or did that sneak in just accidentally maybe?

Woman: Hi. Sorry, go ahead (Jesse).

(Jesse Pines): Yes, we would get – we can make that (unintelligible).

(Paul): Okay.

(Scott Aaronson): And it carried over into the table topics exercises also quarterly where there's not technically even an annual requirement for the way to exercise. And I also was looking down at the healthcare information technology. It was a very last one on Page 27 next page. And it seems to carry over that, that – the model is perfect set up their plan for tracking patients without healthcare information technology, ability to track without. And then tracking without would be the element coming up in the next component and then recovery of insuring and verification of accountability for patients without. So it could be a method just to carry it all the way over very similar to how it was done to above and those should be really moved right next to each other. They're both for tracking with or without technology.

(Paul): Yes, that makes sense. Can I ask (Scott) and everyone but, you know, given the fact that for many emergency management programs across the country the most frequent reason they're actually activating their Hospital Emergency Management Plan is for HIT downtimes. And there are a lot of operational concerns when the HIT downtime is the disaster itself. Do you think that we should be incorporating both mitigation and response measure concepts that

relate to planning and activities that occur when the system goes down? Is that a gap? Are we missing something?

(Scott Aaronson): Yes, that would be a good thing to have incorporated there because we've watched the challenges going on in healthcare every time that they lose the ability to document in that manner, and lose the information or don't have assess ability to it.

(Paul): You know, it's obviously it's sort of an incident specific scenario but it's unfortunately it appears to be one of the most common ones that hospitals are facing. I don't know if we feel like we need to flesh it out more so that's helpful. Any other comments on that?

(Scott Aaronson): Just add one thing if that really does cross all spectrums when we talk about the healthcare system because we're going out to the clinics, to the medical offices, to the – to each entity and as we have more networked medical records that is a major factor for continuity of care.

(Paul): Yes, no absolutely. You know, it's access to prior medical information but certainly of course documentation order entry that, you know, it's results reporting, and safety systems that are all being built into electronic systems. So good I like that. (Barbara), you have a comment?

(Barbara Citarella): Yes, I think this one is actually very important how the facility is going to have a plan when their HIT is down especially with the emphasis and the recent episodes of cybersecurity where many of the hospitals that I've worked with where they've been held ransom and they had to work manually. So I think it's an area that we need to address because we're going to see that more and more.

(Paul): Excellent.

(Barbara Citarella): So we…

(Paul): Excellent, well we'll try to work - I'm sorry, go ahead.

(Barbara Citarella): I think it's an area that really needs to be important. And we need to make sure that this is part of the plan that they could be without their IT for a very, very long time.

(Paul): Yes, perfect.

(Barbara Citarella): That's healthy for the future (unintelligible).

(Paul): Perfect, we'll – excellent. Yes, we'll try and work with the NQF folks and flesh out the measure concepts that work for that. (Glenn), you have a comment?

(Glenn): Yes just to piggyback again on this. I wonder given that the concept of cybersecurity is there a mitigation angle on this effort as well in terms of thinking about cybersecurity standards to potentially prevent or mitigate this particular type of emergency that we want to reflect that in the framework?

(Paul): Yes, I think it's a good point. It's probably worth, you know, obviously cyber events potentially can cause major downtimes but there are other things that come along with cyber as well that, you know, whether it's the data loss, or the financial mitigation or others and so yes it's a really good point. And cyber itself may on top of the HIT downtime require, you know, an additional vendor concept or two so I like that.

Any others on either the HIT in specific or anything else that - of the measure concept that list within – that are here within the emergency management program? All right the next is incident management. And obviously like many things in the system domain they're - they can be pretty broad. But some of these are about organization and leadership, some of these are about outcomes, comments, thoughts on the measurement concepts that are here? (June)?

(June Hill): I wondered about the goals for patients experience during emergencies. You know, it just seemed unclear to me given there might be, you know, different standards of care, et cetera, what does that mean exactly?

(Paul): Yes, good question. I hate to punt on this but NQF can you offer a little background?

(Jesse Pines): Yes, so, you know, we added that obviously, you know, patient experience of care is an important quality measure outside of disaster times. You know, and I think the point of this was not that we wouldn't sort of lose sight of that and we would, you know, specifically, you know, make sure that patients are getting measured experiences during a disaster and also during the recovery period. You know, beyond that there really wasn't a whole lot of, you know, thinking in terms of why, you know, why the, you know, why that would be singled out but we, you know, we can certainly cull that out if people don't think it's important.

(June Hill): No, I think it is important. I just think we need to be clearer about, you know, what we really mean because it's still kind of vague.

(Jesse Pines): Yes, so there are surveys that are sent out to patients after they're discharged from hospital facilities and, you know, more now that – and also from the

specific parts of the hospital emergency departments where patient can measure and record the experience they've had in a survey. And they're – those are actually pretty standard. So that I think the thinking there would be that we would isolate that if the patients who were seen during the disaster time and then also during the recovery just to make sure that we were, you know, maintaining the experience.

(June Hill): Okay, it answers (unintelligible) concept but I think there's probably a different level of satisfaction here than your typical sunny day.

(Jesse Pines): Yes, that's true. I mean there may be, you know, different questions that you, you know that you want to ask there, you know, related to, you know, every day medical care versus disaster times but, you know, that would be again for a measure developer to pick up and help specify.

(Paul): Excellent. (Barbara)?

(Barbara Citarella): (June) just made me laugh first of all. I love (June). The intent of this established goals and then carry that across to the four phases to include that as part of the after action report?

(Paul): I think that's yes, interesting. I think, you know, back to the earlier theme that we have on what we monitor, you know, I think maybe if we reworded the one that says patient experience of care during disaster to monitor patient experience of care during disaster or their response and then of course and then the next one, you know, monitor patient experience during recovery then, you know, those can be potentially data points or data elements that are captured for the after action report for the improvement plan and then, you know, where there are, where there is insufficient performance in the patient

experience and that can be, you know, documented and addressed. Do – would that make sense?

(Barbara Citarella): Yes actually it does. And as I'm reading through it then it makes sense because many patients if we go back and ask them what their experience was it's probably not going to be very good if they've had altered standard of cares or crisis standards of care. But I think if we're going to put it as part of the after action report then it absolutely makes sense to me.

(Paul): Excellent, thank you. (Steven)?

(Steven Cruz): Hi. I actually chuckled. I'm an ER guy. I think the patient experience is important but I think it's important that they actually live which is I guess an important part of their experience. You know, I think I would focus on access to care as a way to sort of measure how well the system is doing in response to surge and response to, you know, perhaps a destruction or disability affecting part of the healthcare delivery system. I think any emergency physician, who actually sees this will have a similar reaction. There's something else I wanted to bring up here. I – oh it's in the next section.

Well actually one other thing. So in addition to measuring population health like in getting back to the comment I made earlier about just the individual as the population but also the community as the population and measures of resiliency which would be a nice direct measure of the effectiveness of the incident management.

(Paul): Got it. Excellent, thank you. (Mark)?

(Mark Garrett): Not to keep beating on this patient experience but I tend to agree. I think the problem is that we're making it too broad. And I think what it needs to be is

broken down into, you know, specific questions because it's, you know, not how the food was or was it quiet or noisy. It's really was there communication and were your, you know, did you feels that your clinical needs were met? I think those are like, you know, you pick two or three out of what we usually measure that really are pertinent because, I mean, you know, patients do need communication. And I think and we may want to say it's patients laugh – slash family because when we evacuate hospitals families need to know, you know, were they told where if it's possible where their family member went and how soon they could be returned back to their, you know, back to their community. So I think it's may be, you know, focused questions for patients and families in their experience of care.

(Paul): Yes no, that definitely makes good sense. And I think again I don't exactly you can kind of play around with the wording a little bit I, you know, if there's a way to highlight or maybe just a separate assessment of have access to care – I like (Steven)'s point a lot that, you know, that we care -- one of the things we really care about is, you know, can patients get access to the care they need through the incident management decisions that are made? So, you know, we can think about how we might word that as a response measure concept.

Okay anything else on the incident management phase? All right we're getting there. Communications is the next subdomain. (Steven)?

(Steven Cruz): So this is on Page 29 of the document that you sent out. It's listed as a communication subdomain. But I think that's mislabeled because I'm not sure this is really a communication element but maybe an incident command, incident management in terms of the identification of high-risk populations, plans to identify them, successful identification during response et cetera, et

cetera, struck me that this - I mean communication's part of everything right but I really think this is an incident command consideration.

Man: Yes.

(Paul): Yes, and thank you for calling that out. It - and part of my brain that actually even is more emergency management then incident management which is (Steve) do you feel strong way whether it belongs in one or the other? I might lean towards emergency management.

(Steven Cruz): Actually I would agree with you still further. I just sort of looked north and saw incident management and thought type.

(Paul): Yes, no I think that makes sense. I think it definitely belongs it there much more than communication so thank you. That's very helpful.

(Jesse Pines): And I think it, this is actually mentioned earlier at the beginning of the call where we talked about, you know, going out and sort of proactively into the community and, you know, identifying where the dialysis patients are. And I know ASPR has spent, you know, a lot of resources in doing that and that sort of thing but like I, you know, I agree with sort of relabeling that as emergency management.

(Paul): Thanks (Jesse). Anything else on communication? Healthcare system coordination is the next. And obviously surge is the next one after that. Okay. (Scott)?

(Scott Aaronson): I would just for the second to last healthcare system coordination the, we've got the partnerships created right there and then the piece about emergency, about preparedness measure should be the partnerships are maintained with so

we can incorporate that there for ensuring to have a method for continuing those relationships.

(Paul): Got it. That makes sense. Thank you. All right anything else on either healthcare system coordination or surge capacity?

All right and then we'll do the last three kind of as a group since they're relatively few current measure concepts in these columns. But so incident specific capabilities in some ways is I think almost is – has been too big for people to have comments in here but this could in some ways go on forever between mental health response as needed, chemical hazards, radiation hazards, you know, the blast injury. You know, do- I invite people to comment on how this subdomain does or doesn't work and how we, you know, may or may not be able to flush out the right measurement concepts to go with it.

And then business continuity I would say either there's a challenge that the word business continuity means very different things to very different people depending on where you sit. And if you're an IT person that has a very specific IT focused need whereas for folks in either the corporate world or increasingly healthcare world we're using it to talk about maintenance of essential functions within the healthcare system. So at least as I was thinking about that this I was definitely trending more towards the latter definition which is kind of beyond like information systems but talking about as I said these essential functions and then the dependencies needed to support those essential functions. And I think we, you know, we talked a lot about crisis standards of care and certainly it's still features relatively prominently in ASPR and HPP guidance so thoughts or comments on any one of those subdomains? We may be getting to the end of a long call.

(Steven Cruz): Could you ask the question again?

(Paul): Sure. Sorry. So I think, you know, we just have – we have three specific subdomains left and the measure concepts associated with them. I think crisis standards of care everyone on the call probably pretty well understands that concept. But for business continuity I – it's been my experience that depending on your background different people use the words differently. IT professionals or IAS professionals tend to use it very narrowly to define the servers and systems to keep the programs running whereas in say more broadly in the corporate world business continuity is defined as the activities that name your essential functions within your healthcare organizations and create plans to preserve those essential functions. So I wanted to see how people wanted to think about business continuity and whether the measure concepts align with that.

And then back to incident specific capabilities, you know, there are of course as we all know lots and lots of different incidents we face from hazmat to radiation to the blast to other kinds of incidents. And you know we have one measure concept there related to behavioral health put there could be more. And I didn't know if anyone wanted to comment on what you think we should do with that subdomain given that we have one measure concept there right now. So (Barbara), it looks like you have a comment.

(Barbara Citarella): I do but it actually wasn't about the incident specific capabilities so I could hold if there's somebody who actually wants to talk about that. I was going to talk…

(Paul): No, no you can just go ahead.

(Barbara Citarella): Okay. I was going to talk about (unintelligible) standards of care. And I was just going to put this and to the group. Do we want to have altered standards of care and (unintelligible) crisis standards of care because we're going to move back and forth and we need to be able to identify those triggers and indicators from (unintelligible). So I put that out to the committee.

(Paul): Yes. Yes I think it's a good question. I think I definitely am like you eager to hear what other people have for thoughts. I know that the national academies have been sometimes using the term recently of crisis standards of care to represent the whole continuum from, you know, conventional to contingency to crisis so, you know, expand it out more broadly. But I don't know if people are comfortable or uncomfortable with that concept or use the term that way.

(Barbara Citarella): When we worked on the crisis standards of care at the Institute of Medicine we actually kind of did break it down from normal to altered crisis. So I didn't - you know, there are certain points right now in our healthcare system we actually probably already at altered standards of care. In the ER, you know, we been (unintelligible) of cardiac ID meds, some types of things. But I don't know if it's that importance that we need to break it out. I just put it out to the group.

(Paul): Yes and I think it's a really good question. (Steven)?

(Steven Cruz): I sort of use altered (unintelligible) terminology. I used to call it altered standards of care. Then it occurred to me as somebody just made the point that there was no place where the standard of care is altered on a regular basis because of standard operating conditions that we don't always well anticipate. I think we should stick with something here and I would probably stick with crisis standards of care. That would be my suggestion.

But the two points first of all there's nothing in the preparedness column. And I think before you determined that you've met the pre-, the community standards of care have been met you probably needed to find what they are. And so that would be part of the preparedness process where you're not just identifying triggers but actually what the local or national, regional community will accept.

The second part of this is that I think it's really pivotal. And I don't know where to put it whether it's here or whether it's under staff training but your people need to understand how this works. And that's how – that's a whole other perspective and you can try to do that just in time but probably challenging.

(Paul): Yes, fair enough. (June)?

(June Hill): Yes, I just wanted to get one other concept on the table before we finish. The after action report I just had a question about honesty in terms, you know, jurisdiction. Government action reports are often very sanitized and marginalized for political purposes. So I wonder whether in health systems, you know, who gets to look at these and if their crediting bodies look at them or state comp classes or whatever does that lessen their ability to be honest? And is there some other mechanism to keep this, you know, honest so the course corrections get made? I always worry about this given what I see in government.

(Paul): Yes, I don't – NQF (unintelligible) you have thoughts on that?

Man: I'm not sure.

(Paul): All right, well I think we'll obviously keep that in mind (June). And, you know, I think, you know, you're exactly right. It's been well documented that when, you know, after action reports and improvement plans are nonspecific that they have some limited utility. So maybe, you know, we can – we'll toss around maybe of how, you know, as a measure of quality that actual, the report reflects the observations or the performance on the metrics observed during the response, something like that. We can see what we can come up with.

Man: Sure.

(Paul): Excellent, all right. Well I think that is the very long list of measure concepts we have made it through. I know that NQF wanted to talk about sort of future considerations and what happens next for the public comment. Is there anything else that you guys want to talk about or did you want to scroll down?

I know we have the readiness measures. I don't know that we're going to be able to get through the whole list in the next 12 minutes. So should we ask NQF how did you want to go through this?

(Panab Baba): I think if we could just quickly go through to see if there were any concerns on the measures listed there since we didn't include them in the slides we sent earlier and this would be - their report would be the first time people saw them. If we could just quickly see the future considerations discussion we could probably push off until the post comment call so this is something that we wouldn't maybe including in the draft report anyways. It's just more to get the discussion started.

Maybe with the last couple of minutes we have here we could just try to see how far we can get and then obviously people can always send more

comments through email. We do need it by Thursday though in order to incorporate them in the report so we can get it publicly.

(Paul): Got it. So I think again everybody has this in front of them. Rather than going by sub domain maybe we'll just try and see if people have comments in the domains. Again these are individual measures that have been identified as part of the initial landscape survey done by NQF that would fit within the – within the individual subdomains. Any thoughts about the, you know, appropriateness or utility of these domains as they been put into the appendix so far?

(Panab Baba): You can see we're scrolling through now on the screen but we can talk about just given the short time we noted we can look at any and think anyone of those domains so staff or staff infrastructure or system. Oh it seems like there's no comments. So people didn't have a chance if they loved it or if they loved it we did. So maybe you could try to have – anyone could hold the future consideration discussions want to make sure that the committee has a decent amount of time to really think through that and give us feedback. But please look at because I – and if we actually go into slide real -click. And then we - just so keep it on your mind and when you go to – we have our last meeting which is going to be a post comment Web meeting we'll definitely be talking about this, so if you can start thinking through it'd wonderful. Yes.

Okay, yes okay. So basically what we're looking to get your point of view is where do we go from here? You know, again this is a mindset like the framework is basically established. What we do to make sure we move this forward? We don't want this to be a dead document that, you know, no one even knows it exists or anything like that so we really want to move it forward.

How do we get these measure concepts out there and actually achieve that level of readiness that we're looking for and then who is going to take the lead on moving this framework forward? As a reminder this is supposed to be more public focused, more private focused than public so we want to make sure that there is, you know we talk through who's going to really move this forward? How do we get where we want to be, wo we'll hold that discussion. Okay we do need to do public comments then we'll do next steps but before we jump to that were there any additional comments from (Paul) or the committee?

(Paul): Nothing from me. I just, you know, I thank everybody for reading through this and giving such good commentary. I think it's a very helpful to continue to improve the document so that's great.

(Panab Baba): Perfect, thank you (Paul), 100% agree. We appreciate so much how active this committee's been and honestly one of the most wonderful committees we've worked with about how active you guys have been so thank you very much. Where there any public comments? So please just raise your hand or you can speak up on the line as well. And while we're waiting for hand raises maybe you can go through the next steps and then we'll check back in to see if there's any comments.

(Nadia Kumar): Thank you (Panab). So for next steps we have our upcoming 30 day commenting period for the rough draft which will be from March 11 through the April 9. So during this time we will also be sending an assignment to the committee for prioritization since we have additional concepts added since we last discussed this. And after that we will be hosting our Web meeting nine on May 9. We will review the comments that were made and for those draft recommendations and obtain the final committee feedback on the report including any strengths and challenges.

(Panab Baba): And then just everyone knows will be sending out more information through evil about exactly what the exercise will be and so on. Okay we don't see any hand raises, last chance for public comment. Okay so with that again we sort of thank everyone for their participation.

It's been wonderful working with everyone and we know that it was a lot to go through with all the measure concepts and everything else in the report. Thank you for everyone leading in and, you know be able to use that feedback. And we look forward to talking to you in May. Thank you.

Man: Okay, thanks everyone.

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