NATIONAL QUALITY FORUM

Moderator: Benita Kornegay Henry
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9:07 am CT

Operator: The conferencing is no longer active.

Feygele Jacobs Hello.

Mark Jarrett: Yes, I'm still here.

Feygele Jacobs: Okay.

Barb Citarella: Me too.

Man 1: I'm still here.

Woman 1: I may have (unintelligible).

Mark Jarrett: They must be having technical issues.

Navya Kumar: Hello. This is NQF. We'll just get started in about a minute. And we'll have other people dial in. We realize some people don't have the dial in information, so give them a minute to do that.

Debjani Mukherjee: Good afternoon everybody and good morning as well, if you're in (unintelligible) places. This is the Health Care System Readiness Final Web Meeting and it's also the Web Meeting #9. Thank you all for sort of bearing with us through all these Web Meetings. It's definitely more challenging to do all this over the web then face-to-face.

Again, my name is Debjani Mukherjee. I'm one of the Senior Directors on this project. And with that, I'm going to turn it over to Navya for a roll call.

Navya Kumar: Thank you Debjani. This is (Navya) (unintelligible). Before I start roll call, I just wanted to go through some Best Practices. So, for our committee members, if you are dialed in, please put yourself on mute and if you would like to talk, please announce yourselves. Or you can always chat in our - the chat box. And please raise your hand for the public. There will be an opportunity later on in the Web Meeting for an opportunity to speak.

So, with that - so for today's agenda, we will go - we'll have an overview of the framework of what we've been speaking about for the last eight web meetings and then we'll go through and dive straight into the report. We'll go into the Measure concept and what the actual next steps are for readiness. And then go through with the opportunity for public comment and next step.

So, the project staff is Debjani Mukherjee, the Senior Director. Jesse Pines a consultant. Poonam Bal, the Senior Project Manager. May Nacion, Project Manager and myself (Navya Kumar).

Debjani Mukherjee: If you could please put your phone on mute if you're not speaking. Otherwise there's a lot of echo and it distorts the quality of our recording. Because we do have transcripts that we use to sort of edit the report and things like that. Thank you.

Navya Kumar: Thank you. So, with that, we'll begin with the roll call. I know Paul and Margaret are here. Scott Aronson?

Scott Aronson: Yes, I'm present.

Navya Kumar: Thank you. Sue Anne Bell?

Sue Anne Bell: I'm here.

Navya Kumar: Thank you. Emily Carrier?

Emily Carrier: I'm here. Just to let you know, I'll have to be jumping on and off.

Navya Kumar: Okay, thank you. Cullen Case, I know he might be coming in late. Barbara Citarella?

Woman 2: I'm sorry, just let me go on (unintelligible).

Man 1: She can say (unintelligible)

Woman 2: Oh, I see, I got it. I missed those specifically.

Navya Kumar: Okay, Barbara Citarella are you there? Are you on mute?

Barbara Citarella: Here.

Navya Kumar: Thank you. Katelyn Dervay?

Katelyn Dervay: Here.

Navya Kumar: Thank you. Alexander Garza? I believe Jennifer Greene will be coming late as well. Angela Hewlett?

Angela Hewlett: Here.

Navya Kumar: Thank you. Feygele Jacobs?

Feygele Jacobs: This is Feygele, hi.

Navya Kumar: Thank you. Mark Jarrett?

Mark Jarrett: I am here.

Navya Kumar: Thank you. June Kailes?

June Kailes: I'm here.

Navya Kumar: Thank you. Matthew Knott? Stacey Kokaram? Steven Krug?

Steven Krug: I'm here.

Navya Kumar: Thank you. Nicolette Louissaint? David Marcozzi? Glen Mays? James Paturas?

James Paturas: Here.

Navya Kumar: Thank you. Patrick Reilly?

Patrick Reilly: Here.

Navya Kumar: Thank you. Marcie Roth? Lucy Savitz? Jay Taylor?

Jay Taylor: Here.

Navya Kumar: Thank you. And did anyone log in while I was going through roll call? All right. And I will pass it to the coaches to provide some welcoming remarks.

Margaret Weston: Good afternoon everyone. This is Margaret Weston. I just wanted to thank you all. A really heartfelt thank you for the time and sharing of your knowledge and experience that you have done with this committee. And I recognize all of the work that we have done has not always been easy. And it's sometimes difficult to capture all of the ideas in a large group and really represent them in a way in which you voice them.

And so, I thank you for your patience and understanding in our efforts to try to do that and to capture everything that you have said along the way. I do want you to know that Paul and I have absolutely heard your concerns, both on the calls and via email, with the struggles of getting this body of work to a place that we all feel is an acceptable reflection of the points of view that have been brought together within this committee.

I hope that, at least some of you, will be able to address your concerns in this updated version that we'll see today. But we absolutely welcome your input and invite you to share freely your opinions and concerns and ideas, so that we can make the final edits meaningful to this group.

I do think it's very important to know that this is just the beginning of the work and that we started with kind of a foundation. But that the NQF Team has assured us that this foundation will be built upon and evolve. And so, I hope that there will be additional opportunities for each of you on this committee to share your diverse expertise on this topic as it continues to develop and evolve.

So, again, thank you so much and I welcome any comments from Paul as well, as we move on.

Paul Biddinger: Yes, I think I clearly want to echo what Margaret said. You know, she and I spent a lot of time talking together and talking with the NQF Staff and I can't emphasize enough how much I support what she said. That, you know, everyone's comments, both on the calls and by email and otherwise, have been really, really valued and I think really well taken. I think, you know, the passion that so many people are bringing to this is extraordinary. It's so important.

The one additional comment that, I think, is maybe hopefully a little helpful as we dive into the work for this call is, you know, this project, maybe more than many, has been challenging just because of so many different terms and definitions and concepts that are tough to define and sometimes are defined differently by different folks. And so, one thing that I think will be very relevant to today's discussion is, just sort of a reminder of the definition of the measure concepts.

That, you know, way back at the very beginning of the project we were provided with sort of the elements of measurement of (unintelligible) framework and kind of how CMS and NQF look at it. And, you know, our

goal, our task, as a group is to define the domains which are, of course, the, you know, high level ideas within the framework.

Some domains will break that into smaller, bitesize chunks and then measure concepts. And I think one source of challenge has been a measure concept versus a measure. And so, in the NQF lexicon and the measurement framework lexicon, a measure concept is a description of a potential for an assessment tool. So, a measure concept has to talk about the planned target and the population.

This is what we're trying to measure, but it's not the actual measure itself. And I very much appreciate and agree with lots and lots of the comments that have been made about, you know, specificity and smart elements of measures. And I don't know whether it's helpful to anybody or not, but just as a reminder that the list of measure concepts that we'll be going through are not, in fact, measures themselves.

And so, the individual items are not going to be things that are applied to health care systems to look at their readiness. It defines how the measures should be developed. So that the motor concept sets up measures for development. And, again, NQF Staff can correct me if I say this incorrectly, but like I believe it's correct to say that NQF doesn't develop measures, but they develop frameworks and within that framework is a measure concept. And then the next step, and as Margaret so nicely said, this is just a first step in a very big process that needs to continue to evolve and grow and get refined.

But one of the big and important next steps is to take the most important measure concept and look at how we can develop - or how others can develop some things (where it doesn't get us) - how individuals can develop objective

and really appropriate measures, the measure of the content within the measure of concepts.

So, that was my only additional comment. And then Margaret and NQF folks add to that, but hopefully, maybe a little helpful for framing some of the discussions we are about to have.

Margaret Weston: Are there any questions about that as we move forward? Okay.

Paul Biddinger: All right. So, I believe the next task in front of us is to move onto finalizing the framework. Is that correct?

Debjani Mukherjee: Yes, it is. So, we will screen share. If anyone has any other questions about the other parts of the report, we're actually going to jump into the measure concepts now. But certainly, if you have any other questions or comments about, you know, either designing principle, or domains and subdomains, please let us know as well.

But I know we changed a lot from the measure concept since the last time. We've published the report for commenting, so we do want to get your input on that. And I think we are screen sharing it now. It has some track changes on it and this is the same one that the committee received first.

Margaret Weston: So, many of the comments that you sent in, as we scroll through, you'll see that they were addressed. But you can see that, certainly, the subdomains, maybe we should address those first. We've worked within the subdomains pretty comprehensively, but very open to any discussion of things that you believe may be still missing from a subdomain perspective, just to touch on that first as we go through.

I just want to open that up for discussion before we move on specifically to the measure concepts. All right. Hearing nothing. Let's talk about the Measure Concept. And I think the best way to do this is really to go through by subdomain.

Looking at the Mitigation Preparation Response and Recovery Measure Concepts. We can go line-by-line just so that you have the opportunity to kind of look at each of these measures. If you have any comments on that line, we will take those comments and make sure that they are captured.

So, from a staff safety perspective, the very first line, the set of measure concepts under the first staff safety box. Are there any comments or concerns about the way that that has been created? Is there anything you feel is left out or missing?

Paul Biddinger: I would, you know, hopefully emphasize that, please, we'd love to continue to hear from you freely during this call. Margaret and I tried very hard when we did some of the artwork to (work with these other concepts) to incorporate a lot of what you brought up before. Some of the different thoughts and concepts.

But if you think that anything is not appropriately captured or it's not represented in the right way, we really would love to hear from you about that.

(Gwendolyn Geff): And Margaret maybe - this is (Gwendolyn Geff) - maybe we should remind the committee that they can raise their hands and chat in case they're needed and they're trying to speak and we're just not catching them.

Margaret Weston: Excellent and I thank you so much for that. I know some of you may not actually have, well, hopefully you have access to the video, but may not be

able to be in a place where you can speak. So, please feel free to raise your hand inside the application.

Paul Biddinger: I think I see June you have your hand raised.

June Kailes: I do. I just wanted to acknowledge that I got this really late in the day on Tuesday and didn't really plan. So, you're not going to hear a lot from me because I really haven't had time to review it yet given the short timeframe in which it was received. So, for me and others that are probably in the same situation, how much time do we have to give you feedback after this call?

Margaret Weston: Would the NQF Team like to address that?

Debjani Mukherjee: Yes. We'd really love all of your (points) during this call. But, you know, certainly if you need more time to digest, probably by, let's see, end of next week would be really great. By the 17th would be fantastic. Because we do need to revise the report and make sure everything is finalized and then sent off for copy editing and what not. Because that process just takes a little bit of time.

June Kailes: Thank you.

Margaret Weston: Okay. I have not heard any comments about that first Staff Safety line that's showing. Any questions about this second line under Staff Safety? Anything that needs to be added? Any concerns about verbiage? Anything you would like to make a comment on?

Paul Biddinger: Steven I see you're commenting (closing - remove from there) (I think GTE) certainly could (reverse that).

(Gwendolyn Geff): Margaret, this is (Gwendolyn Geff) again. I also wanted to remind the (committee) to June's point that the concept hasn't significantly changed since we did the exercise earlier, which I think was a couple weeks ago. And I know, June had participated. So, just reassuring her and other committee members who felt like they might not have had enough chance to review it.

For the most part is the concept and ideas is exactly the same as the concepts we set earlier for your review before this meeting. The only - there might be small word changes and maybe adding a little bit more clarity. Just so everyone knows.

And Margaret, maybe since we're not getting - you know, people aren't voicing much, it might be that they are not concerned. So, maybe we can change the language to be more affirmative by saying, you know, if you don't have any issues, we're assuming that you are content with it and we're maybe asking is everyone okay with it. Just so we can make sure that the lack of silence is a confirmation that everyone is content with this and not just that they don't know how to respond.

Margaret Weston: Sure, absolutely. And with that said, I will take any comments on this second line. If you have any changes please speak up. But if you believe that it's acceptable as is, I'd love to hear your confirmation of that as well. All right. I will take no comments or your silence as affirmation. Again, if you haven't had the chance to review these early, please take the time to do that and you can certainly send in your comments to the NQF Team.

Steve, I know that you have a comment on this next group as well. And I - it's hard for me to see whether - actually, I'm having problems with the video portion. I apologize, but I - my - I keep getting an application failure. I don't

know if - Paul, if you can see them fairly well if you want to take the next couple and see if I can resolve this.

Paul Biddinger: Sure. Yes, I think I can see reasonably well right now. So, maybe we'll take the next two lines together since they are both Staff Capability Subdomains. And I think, definitely, you know, training includes both initial training and skilled maintenance. I think, Steve, that was a really good point. Again, I would definitely, I'm open to, or I'd love to have any suggestions on how we might word snip it otherwise.

But the idea with the use of, you know, creation resourcing and active process is to say that staff both get appropriate pretraining, but skills maintenance. So, any other comments on capabilities. You know, certainly this subdomain is meant to say that either hospitals have to have plans to utilize and deploy the appropriate staff and/or create training programs and move staff around with the right necessary additional training in order to respond correctly. So, any other thoughts.

Mark Jarrett: Yes. This is Mark. It may not be necessary, but do we want to put somewhere just the caveat within regulatory boundaries. Because unless there's a declared emergency, you know, there are things that we might think we want to do, but we really can't from a regulatory viewpoint.

Paul Biddinger: Yes, I like that a lot. I think, if I may, do you think if we added that within the response column, that that's the most appropriate place where it exists?

Mark Jarrett: Yes.

Paul Biddinger: Or maybe we could put both in the planning and response column?

Mark Jarrett: Yes, I think in the planning and the response columns would be good.

Paul Biddinger: Great. That's a great suggestion. Thank you. Scott, it looks like you have a comment.

Scott Aronson: My only question there is, should that type of comment be really more something that's at the top that just calls out the aspects within regulatory boundaries or something, that that is a perception on most of these. And unless we're dealing with, you know, a specific event that requires us to move outside of that - so it seems like that will carry over in a lot of the areas?

Paul Biddinger: Got to put it as sort of a caveat in a preamble somewhere that it applies throughout and then sort of directly addressed in some of the crisis standards of care sections. But otherwise it's an ongoing assumption that it's always within the existing regulatory boundary.

Scott Aronson: Yes. It just appears we should give that balance and then allow people, obviously, if it's very clear that it needs to be there for crisis standards of care and others - but yes, for most of them it would be a standard caveat out there.

Paul Biddinger: Perfect. Perfect. From the NQF side, does that make sense if we put in there, sort of an asterisk or a preamble something?

Debjani Mukherjee: Yes, no that's perfect. We were thinking about that as well.

Paul Biddinger: Excellent. Great. Any other comments on the capabilities measure concepts there? Okay. Shall we move onto Staff Sufficiency? We'll start with - it looks like we're going to crossover a page break. So, the first line is staff sufficiency and again, sufficiency we split out from capability in the sense that sufficiency is really having, you know, appropriate numbers where possible or

trying to ensure that they're appropriate numbers of staff with you by training, but separating that from their capabilities.

Any thoughts on the sufficiency measure concepts?

James Paturas: This is Jim Paturas. I have a question.

Paul Biddinger: Yes.

James Paturas: On the second page I'm looking at - it looks like page on here, probably - yes, so it's probably Page 26 on the screen. Where you talk about, on the upper one, it talks about the credentialing. Then on the one below it talks about the volunteers. Do we make the assumption that, for instance, on the volunteers in the second box, since there's no mention of credentialing, is that covered in the upper box? And are they connected?

The other thing that I - the reason I ask is because there's going to be different terminology. For instance, in the upper box that speaks to the credentialing across each of the boxes, the words that uses external staff; wherein the second set of boxes across that same spectrum is the word that uses volunteers. Are we speaking of the same? And if not, which is fine, then one of the things I would suggest under the second box is the identification of credentials.

Paul Biddinger: Yes. It's a really good point. I can speak for my comments and Margaret or NQF folks may have different. But my assumption in thinking about this was that external staff would be either coalition or regional staff sharing, as well as potentially other external sources, like (NGO) or, you know, DMAT federal other response teams that are formal versus volunteers which could be either

spontaneous volunteers or depending on how you looked at it, MRC volunteers.

I think your point is definitely that the volunteer line, if they are to stay separate, certainly needs the wording about credentials, privileging, and licensing ensuring of licensure. But I don't know if others think those should be separate or if it's just redundant to have them separate or not.

I know, you know, most hospitals certainly first reach to other staff sharing or MOUs or other formal arrangements before they return to spontaneous volunteers.

Margaret Weston: So, Paul, this is Margaret. I think you're exactly right. I think we separated them out for that reason. So, if we need to mirror that verbiage from a credentialing prospective into the volunteer, I think that's a great idea.

Scott Aronson: You know, this is Scott Aronson, if we think about Joint Commission Standards on there, we've got the Licensed Independent Practitioners and then we have then a separate one that goes for kind of, all other people providing volunteer support in there. So, I think it creates a little bit of a challenge as to what that term is.

We almost, for purposes of this, could combine them or we just need to define it better as to what our intent is between the two.

Margaret Weston: So, are you suggesting maybe in the first one putting that external staff and volunteers? Or were you thinking of different verbiage?

Scott Aronson: So, if we look at the two, we could take the first one and have that to be more on the professional staff, clinical staff that are going to be involved. And have

the second one being around staff that are not going to have privileges at the institution for anything. There will be volunteer support. That could be one way.

Or it could be a merge of the two. I'm just saying we need to define it better as to what that means so it - Paul was coming out with a good, you know, starting to define what it was. And then I heard MRC put into the volunteer one where it could have, kind of carry over onto the other side when you talk about response staff, like DMAT and others.

So, I think it will be confusing if - for other parties, as to what we're trying - what our intent is and what we're trying to mean by the two different categories.

Paul Biddinger: I think that's a great point (unintelligible) the external staff in the - sorry, the MRCs and the volunteer group. I like the way that you characterized it though. That if we said, we (unintelligible) ensure appropriate credentials, (unintelligible) and licensing of, you know, formally requested or formally utilized groups of external staffing. And (I'm sure) there's probably slightly better language than that - which then would encompass DMATs and MRCs and NGOs, you know, the regional or coalition staff sharing (unintelligible). And then lead volunteers just as volunteers.

I think, for what it's worth, my tiny challenge with doing independent practitioners or providers versus others, is, of course, the whole other big category of licensed medical staff who are not - that don't require privileging, but you know the nursing staff and others - and it seems confusing to me to create a separate column, or separate category just for providers even though joint commission breaks it out that way. So, should we talk about…

Scott Aronson: I like that. Well that sounds good, because if you're putting one as almost the requested people coming in and second as just any volunteers coming to you - that could be a good differentiator right there.

Paul Biddinger: Okay. We can definitely play with that language a little bit and try and get it a little cleaner. Excellent. I think that's a really helpful comment. Is everybody else okay with that idea.

James Paturas: Yes. Yes, this is Jim again. Yes. And I think we need to keep in mind that when you look at the two boxes, they do totally different things. The upper box is all about, what I would consider, something you do in the pre-event. It's all about credentialing.

Where the second one is really about, what do you expect these people to do? Their roles and responsibilities. So, I think we need to keep that in mind too. But one builds off of the other obviously. No matter if it's just a stand-alone volunteer, if you will. Or as we talked about previously or somewhat credentialed professional and clinical staff.

Paul Biddinger: Perfect. Okay. Any other additional comments? I think I heard one more voice? All right. So, again, I think just summarizing, we're going to more or less keep the two rows as they are, but we'll add some language to the external staff to clarify that these are formal arrangements with groups of external staff to be inclusive.

And then the separate one would be spontaneous volunteers and we won't try and separate beyond those two distinctions. So, that sounds great. On that third line of Staff Sufficiency. This got, I think there was some good discussion. I definitely appreciate, Steve, your comments. Anything beyond what's there you see in the track changes about root causes of absenteeism,

and otherwise making sure that both absenteeism and attrition are managed and being tracked. Okay.

Training. So, transitioning now. So, the first line was intended or the set of measured concepts were designed to address, sort of, the breadth of disaster skills readiness and ensure that hospitals maintain appropriate programs for - health care systems maintain appropriate programs to ensure that all staff are ready to an appropriate level.

And I think that - I appreciate why that's a difficult measure concept because it's so vague and so broad. So, again, definitely not measures in this category. But the idea is that people understand there's an Emergency Operations Plan. How they would be notified when the plan is activated. They understand what their first responsibilities are. They understand how they work within their systems or their hospital's EOP and ICs.

But with Steve's additions, are people happy with that? Do you still think the language is not quite right? Does it need more word snipping or editing? Okay. Should we move down to the next line? We have three more lines worth of measure concept here related to - related to staff training. Again, there's a comment there about Assessment of Baseline Resiliency.

Anyone want our - Steve I don't know if you want to say anymore about that comment about, you know assessing the baseline, tracking the baseline and just otherwise concept (unintelligible) right there?

Steven Krug: Yes. Thanks. Throughout this category, I mean resiliency isn't (really) the ability of folks to ferret their way through this and be part of the response, as well as maintaining everything else in their lives. In addition to sort of

identifying things like what causes (as to why) people can't participate or have to leave.

And we're obviously not suggesting (open) measures for resilience here because that's another one-hour conversation. But it would be good for there to be some baseline assessment that can provide the foundation upon which improvement would occur.

Paul Biddinger: Excellent. I think one thing that we haven't maybe represented as much in the measure concepts, but maybe I would appreciate suggestions if folks thought we maybe should leave in is the tracking performance of the time. You know, certainly a lot of these measure concepts are about, you know, sort of moments in time. But we haven't really talked about or addressed a lot of how you follow a lot of these moments over time and demonstrate continued progress.

So, there are some in there as we get later in the document, but is there anything specific to training now that people want to add to leave that in or - again, please do bring it up as we continue to go through this document. If you feel like we're not documenting where the baseline is and we're proving that it's either staying steady or improving over time.

Mark Jarrett: This is Mark. I would assume that, you know, if you do the right training that obviously they're either going to be competent or not competent. So, if they need the competency that's fine - I think probably leave it somewhat binary.

But the only other issue is, you know, do we want to talk about the fact that training has to be evaluated more than (annually) because you may have (unintelligible) during the year of people who you think are trained to do certain things and then by mid-year, you know, a quarter of them could have

left and now all of a sudden you're left with a (hole) - that you thought you had trained people. So maybe there needs to be some checks several times during the year, maybe quarterly, to make sure that the staff that's been cross-trained up has still, that you have enough staff with that expertise.

Paul Biddinger: Got it. Excellent. Let me - and we'll kind of think about the words, you know, annually or, you know, otherwise as needed, or periodically reevaluate and something. I think that's a valuable point and we'll try and thing of how we might change that language to take that in. June, I see you have your hand raised.

June Kailes: Yes. I think in training, we might want to consider going beyond the (wine and dine) per year, or whatever the timeframe is. Because some of this content needs more of a continual improvement process beyond the (hot washes and anthrax) reports and so, I always wonder about how that happens. Is there a team that works together to make the improvements? It always seems to be a little bit of a black hole, how that really happens and how it's done in a team effort versus just oh well, (unintelligible) will take care of that?

So, maybe looking at something like - you know, where there needs to be some team effort to make it more real. you know, it's more than a competency training alone.

Paul Biddinger: No, I like that. Maybe if in that second column there, where it says creation, resourcing, and delivery method of training and (unintelligible) maintenance. If we said something like individual specialty staff and staff teams based on identification of needs and then we can change the annually and as needed language to encompass a little bit more of a concept of what Steve was just saying.

That way, you know, if you have, say, a Bio flex Team that has to work together and train together or, you know a Hazmat Team, or even a Trauma Team, that sort of, you know, we can't get too specific because there's so many possible different teams. But if we change that language to be for, again, individual specialty staff and staff teams, that would be encompassing. Does that sound about right?

June Kailes: Yes.

Paul Biddinger: Great. I think those are helpful thoughts. Anything else? Any other comments on this grid in general of the other staff training measure concepts that we have here? Okay. Next. If we can move onto the next area.

All right. So…

Margaret Weston: And Paul, just to let you know. I am back up. So, anytime you want to turn over…

Paul Biddinger: Excellent. You want to (go)?

Margaret Weston: Sure. I'm happy to do that. So, the next area is staff support. And this is really speaking to all of those potential personal supports and response needs that may occur from a staff perspective, addressing more of the education, kind of, how are they fed, housed, laundry, food - all of those things that we need to be thinking about from taking care of staff during a disaster.

Would like to know your feedback. Anything you think might be missing? Any comments you'd like to share? All right. Seeing no hands raised. I will take it that you are affirming that we have covered what we need to cover in that area. And we can move on.

Paul Biddinger: I'll take this last one. We can just alternate Margaret. And the last half support set of measure concepts obviously is extending beyond the individual staff members themselves. But their families and their caregivers and making sure (if) that's accounted for. Any comments, thoughts about that? Do you think - is there anything else we're missing in order to make sure we've captured the breadth of where we need to develop measures that look at staff support?

James Paturas: I guess the only - this is Jim Paturas - I guess the only question and maybe it's someplace else, I can't remember - let me just look here - would be as you think about staff support, is there a need to make it clearer that the, sort of, you know, any of the social psychosocial and mental health support that would obviously be needed in a lot of situations?

Paul Biddinger: Yes, I think it's a good comment. We do have some of that - the mental health and other needs documented a little bit earlier, but you know, when you get a chance scroll up a couple lines and if you still think we're missing it, definitely, you know, let us know. Because we'd love to know if that's a gap?

James Paturas: Ys, will do.

Paul Biddinger: Okay. Thank you. And Katelyn, I see you have your hand up.

Katelyn Dervay: Just, and this is more, it might just be worded, but in the first, under the mitigation, we have discussion of resources available prior to, during, and after. However, in the recover, we don't have anything about support available for the staff. It's more just improvement. I don't know if it needs to be in both sections to make sure…?

Paul Biddinger: Yes, (it does). No, it's a great point. I think it may be a little bit of wording. So, I think that's what's in the - in the design of this it was clearly meant to go through the recovery phase. And then so the recovery measure concept was about seeing if what you did in preparation response recovery was all adequate.

But I think you're right that we need to sort of have more wording that says during and after the disaster to just make sure that the expectation is that the resources extend well past the incident itself. Which is certainly when, you know, a lot of those recovery resources are needed.

So, if we amend it to say during and after a disaster, during the - I know the wording gets funny. Because if you put it in the response phase, then it's not necessarily in the right place. Is it okay if we put the word in the response measure concept? Or would you like, we could actually also just create an additional line item there within the recovery measure concept and have those two things be separate.

Katelyn Dervay: Yes, I just think something in that last box. And maybe a separate one. Because I think services to help families - you know, the staff and their families get back to their normal living is important.

Paul Biddinger: Oh, absolutely. Okay. Do folks agree with that? Any other comments on that? I think we certainly don't want to end up looking like it suggests that these services during recovery aren't extremely important. Okay.

Margaret Weston: All right. The next Subdomain is Stuff. And the first line here is the Pharmaceutical Products Subdomain which really covers the identification of appropriate levels of pharmaceuticals that are necessary. Certainly, from a preparedness measure is looking at the appropriate acquisition in the (toy)

storage kind of distribution network of pharmaceuticals and then tracking and managing those pharmaceuticals across the board.

Would love to open that up to discussion. Please let me know if you think there's anything else, we need to add specifically to this area. Happy to entertain those ideas. I see Katelyn - no, yes, Katelyn. Is that - are you wanting to comment on this one? Or was that from…?

Katelyn Dervay: No, it's for this one too.

Margaret Weston: Okay. Please speak up.

Katelyn Dervay: So, just with this one, I think, and not just for the pharmaceutical, but each of the different subgroups within the subdomain. We talked a lot about par levels and having inventory. The two things I recognized after the fact, that we didn't, is appropriate storage. I think that becomes an issue with any of these supply products. That we need to have a place to store them that also meet regulations.

So, whether it's the sterile products or things like that, that they're not in heated environments and temperature controlled. And then in the event of a disaster, there's appropriate power in things. So, it's kind of hard because it goes between the stuff and the systems. Or infrastructure.

But maybe just in each category with the par levels discussing appropriate storage.

Margaret Weston: I think that's a great - NQF I hope the team has captured that.

Paul Biddinger: And I would add...

Katelyn Dervay: And then the second part…

Paul Biddinger: I would add security to that too then.

Margaret Weston: Yes. Another great point.

Katelyn Dervay: And then I did - it was kind of more of an overall, which goes across all of the, I think, it's three subgroups within this - is kind of how to distribute and not just - I think, we're all comfortable with regular distribution, but because of the fact that there's alternative care sites or potentially temporary sites for patients, something in there just that there's processes in place to make sure those things are happening and that we're testing those and adjusting those later on.

So, I don't know if that's like a line maybe, for all of them. Or if that's a system process. Which, I looked through and I couldn't find a good in the system for it.

Margaret Weston: Okay. So, you just recommend adding an additional line for - within each of the subdomains to address distribution, more the logistical piece of how things happen?

Katelyn Dervay: Correct. All of the different things. Especially pharmaceuticals, may have regulatory issues as well. So, and are often not (staged) where some of these alternative care sites are.

Margaret Weston: Okay. Any other comments? All right.

Paul Biddinger: We'll actually move onto the next line.

Margaret Weston: Yes.

Paul Biddinger: So, now the next - oops, sorry - the next line of measure concepts addresses specialty pharmaceuticals and so, obviously, some of the things that either we're thinking, of course are, nerve agent antidotes. Or biothreat antibiotics. Or specialized things. SNS-esque assets. Thoughts, concerns, comments on these?

Margaret Weston: So, Paul, Steven has made a comment in the comment section about perhaps the concept of ongoing tracking of performance should be a general principle in the introduction. Can't approve what you don't measure. Would you like to see any more on that, Steven?

Steven Krug: Yes, well no. It's just the general principle that could probably apply to many of these measure concepts. And so, I guess there are two ways of doing that, inserting that concept for key measures. But also, perhaps making that point somewhere in the document so, it looks like the best practice of evaluating performance. And not just episodically.

Paul Biddinger: Yes. I think that's a great…

Margaret Weston: So, Paul, if we…

((Crosstalk))

Margaret Weston: …in the narrative?

Steven Krug: Just perhaps. I mean, again, it really applies to nearly everything that we're going to be going through here.

Margaret Weston: Absolutely.

Paul Biddinger: I think, that's really - they're really good points. That, you know, as people develop individual measures for these measure concepts, (they) should be collected not - you know, in general, not on a one op basis, but on an ongoing and repeated basis. (If you had) say, you establish a baseline and say, hopefully documents improvement. I think that's a great point and, potentially, within the main body that will be a really good addition.

All right. And any - we'll just move down to the second line and hand it back over to Margaret. And anything on the local pharmaceutical measure concepts there? I think you can (reading) through some of the inventory management concepts that we previously picked up on storage and requirements and security. Okay.

Margaret Weston: All right. So, the next line is really addressing things on the national level and looking at the processes creating resources for national cache' or national cache of resources across the board.

Tracking and monitoring and then really developing (that) correction plan to make sure that these national resources are covered. Any comments on the verbiage? On anything else that might be missing? Love to hear your comments. All right. I think we can move to the next subdomain.

Paul Biddinger: I'm good. And then the last couple - what's the name - I'll get on one screen…

James Paturas: This is Jim Paturas again. Just one quick comment back on Durable Medical Supplies, but it's probably throughout the document. When we mention the word coalition members, is that the final terminology? Since most of what we

see and hear and deal with from the federal government on the state level is Healthcare Coalition.

So, instead of just saying coalition, not to confuse it anymore, is it more appropriate keeping the same naming convention as Healthcare Coalition Members?

Paul Biddinger: Sure. I think that's very appropriate. You know, that is absolutely the terminology that's used. You know, there is a little bit of variability about how much there is or is not identification with some health care systems with their coalition. And so, there is a little bit of vagueness allowed there for anyone else. But I think, we definitely want to be consistent with clearly, what's, you know, the trend and the policies that exist.

So, unless anyone has objections, that certainly seems very reasonable to me. And Steve, it looks like you have another comment?

Steven Krug: Yes, hi. So, now that we are sort of at the end of pharmaceuticals and actually, I'll be making the point that's made in the first row for Durable Medical Equipment. Nowhere in the domains that we've just reviewed for various pharmaceuticals is there any consideration for the preparations that are really necessary to be prepared to (stents), countermeasures, or pharmaceutical products to vulnerable populations which might work (their) different formulations, different dosing. You know, strategic national stockpile is not what I would call a pediatric stockpile.

That's why, I really think, I'm not sure where to put it in terms of which row. But much as you stated in this first row here for Durable Medical Equipment, there really needs to be something that reflects that for pharmaceutical products.

Paul Biddinger: Yes. No, I like that. If we created something of a mirror of that row for the first row of Durable Medical Equipment that (addressed) it's own populations there, but came up with slight changes to language that said, you know, identify - identification of the essential, either steps and processes or potentially supplies necessary to deliver pharmaceuticals to vulnerable populations including children, I like the word there.

Which gets to, as you said, the doses, but you know, the crushing, the compounding. You know, whatever is necessary to prepare medicines for pediatric or other populations, would that be good if we just added a whole separate row, but tried to incorporate that concept into the pharmaceutical products subdomain?

Steve Krug: Yes. I think it would. And then I think the point that was made earlier about regulatory requirements for certain countermeasures that may not be approved. That's going to be part of the planning when you're distributing to pediatric population.

Paul Biddinger: Yes. (Very good). Okay. And definitely we want to add those rows into there. June, I see a comment from you.

June Kailes: Yes. On the Healthcare Coalition, I think it's good to use that, but to not be confined by it. Because other coalition partnerships, community partnerships, that go beyond the health care coalition when we think about health systems. And so, I think we need to recognize that in the language, somehow.

And then I have one more point after that.

Paul Biddinger: Okay.

June Kailes: So, do you want to deal with that one first? Or…

Paul Biddinger: Yes. I don't know if Margaret or the NQF Staff, if you have a thought right now. I think definitely it's a good point to make, to make sure that this is inclusive. Within the document I'm struggling to think of exactly where to put that right now. I don't know if others have maybe a thought. But we can definitely review the document to try to see where that fits.

I don't know, again, Margaret or NQF folks if you have a thought where it might thus be appropriate in terms of definition or a comment?

Margaret Weston: Sure. June, were you talking about - there's one mentioned, at least here in this section, regarding coalition - that pharmaceutical products? Right there at the middle row, first column. Do you want us to just - are you saying you want us to leave just this coalition so it encompasses health care, as well as Non-Healthcare Coalition?

Or do you want, you know, something further that (unintelligible) what coalition means somewhere else and maybe use an asterisk? Within the entire table?

June Kailes: How often is Healthcare Coalitions - would they be mentioned? Because I had to look at every column to exactly see where it might be (fine) or might be confining.

Margaret Weston: June, where Healthcare Coalition, that verbiage is used, would you feel more comfortable with something around verbiage such as Healthcare and Community Coalition partners?

June Kailes: That'd be fine. That'd be fine. Because I know, sometimes health plans, for example, are part of coalition. But sometimes they're part of (unintelligible).

Margaret Weston: Good point.

June Kailes: So, the other point is. You know we, in the (circle) (side) we don't use (unintelligible)

Margaret Weston: Sorry Margaret. We can't seem to hear you. You're breaking up. Will you repeat what you just said?

June Kailes: Sure. In terms of vulnerable population - can you hear me? Hello.

Margaret Weston: Perfect.

June Kailes: (Unintelligible) because we're all vulnerable populations when it comes to emergencies and disasters. And when we're kind of, again, (high populations) that, you know, we're referring to, we've taken these (unintelligible) you know, the disproportionately impacted people or populations. Because vulnerable (unintelligible) emergency. So, (unintelligible).

Margaret Weston: Sorry, June, you're still breaking up. Will you repeat just the last couple of things you just said?

June Kailes: Right. Suggesting we use disproportionately impacted populations instead of vulnerable populations. As we're all vulnerable during these times of emergencies.

Margaret Weston: Okay. Yes. All right. Unless anyone else has any thoughts on that wording, we know that that word, we've gone back through vulnerable, at risk,

disproportionately impacted. If anyone else has any suggestions on the wording, please let us know. Oh, I think Steve, you had your hand raised.

Steve Krug: Yes, again, I don't think we need two wordsmiths here. I think vulnerable and at risk are represent terminology that's used by, you know, federal planning groups and local planning groups. Depending upon how the disaster occurs and where it fits. Then there are members of the population that are clearly disproportionately affected because they just happen to be in the wrong place at the wrong time.

Paul Biddinger: Yes, Definitely, agree. Okay. All very helpful comments. Thank you. Were there, on the last of the Pharmaceutical Product, I just want to make sure we didn't skip over that. We were talking about annual review, appropriateness of stored pharmaceuticals, stockpiles, cache. Any comments on those measure concepts and then we definitely want to get into the Durable Medical Equipment?

Okay. So, we'll move into Durable Medical Equipment. We have the first row here. And I think a very good discussion about vulnerable and at-risk populations that's been here. Any other comments on this first row?

Okay. Then we'll move onto the next page.

Margaret Weston: All right. So, I think we'll take the next two Durable Medical Equipment lines together. The first being, really identifying inventory processes to - across the board looking at practices for inventory locations and identified equipment that's necessary during disaster. Tracking and monitoring. And then really looking at those improvement plans and action plans after action plans.

The second line is looking at more, again, how is Durable Medical Equipment spread over coalition members? How do we use those coalitions appropriately? Creating coalition, how do you thread the equipment and use equipment and maximize coalition strength looking at, again, tracking, that during a disaster and then developing improvement plans?

So, if you'll take a look at those two lines. Any comments, concerns, additional verbiage that may need to be added to these two? Please let me know. Happy to talk about those two areas.

Barb Citarella: Hi, this is Barbara.

Margaret Weston: Hi, Barb.

Barb Citarella: And I'm looking - the statement about amongst coalition members, do we not want to say the Healthcare System? There are lots of Subacute Care Providers that are not members of a coalition, that need to share Durable Medical Equipment. Example, Home Care.

Many of the home care providers are not members of coalition.

Margaret Weston: Sure. So, you're saying to change the verbiage there from coalition members to the Health Care Delivery System or Health Care System.

Barb Citarella: (Unintelligible) System, yes. Yes. That's what the document's for, correct?

Margaret Weston: Absolutely. Thank you.

Barb Citarella: Thank you.

Margaret Weston: Any other comments about these two lines? Any addition?

Paul Biddinger: All right. June. Yes, is there a comment?

June Kailes: Yes. Just the last go-round of disasters in 2018 and 2017, we saw non-profits like the (Unintelligible) Center and other technology. It's just (unintelligible) Centers being tapped and used for identifying and supplying DME. So, I just want to make sure that the langue recognizes that technically those kind of supports may rest outside of the Health Care System.

I don't know. It might be too much of a fine (weed) point, but just to recognize that the whole block of people working on resupplying DME. So, (not be) only confined to Health Systems. I don't know how to deal with that language, but the idea is important.

Paul Biddinger: Fair enough. Fair enough. Excellent. Thank you. All right. Consumable Medical Equipment and Supplies. You can scroll down to that. So, obviously the language looks very similar. We've had some discussion already, I think, on the population language in there. Any other comments? Any suggestions? Anything else on these measure concepts? All right. And then maybe we can scroll down to the next, maybe we can fit all three lines on the same page. Not quite, I guess.

So, much of the language obviously looks similar to some of the previous language about pharmaceuticals in terms of inventory and stock rotation. This is where (TPE) is included. And then there's definitely resource sharing. Measure concepts that are listed here and related to consumable medical supplies.

Any comments, suggestions, or criticisms of these measure concepts? Okay.

Margaret Weston: All right. We will move onto the Nonmedical Supplies. There are three lines here. It's really - the first line is identification of critical needs. I'm really looking at those Nonmedical Supplies. There's the (Omeros) Pharmaceuticals and Durable Medical Equipment.

Identification of a process looking at annual view, inventory, rotation of staff, and then, of course, look at, again that verbiage around coalition members and sharing resources among coalition members. And I think the point is well taken around that verbiage and we should probably carry that - pull that through wherever that verbiage is in this document. So, we will note that as well.

Any concerns? Any comments around these three lines for Nonmedical Supplies?

Paul Biddinger: Okay. We're halfway through our Subdomains now - or through our Domains. So, now we're moving into the Structure Subdomains in the measure concepts. We have the first two here for existing facility infrastructure. The first one is, I think, really straightforward. You know, straight out of all of the regulatory requirements about looking at your infrastructure needed to sustain operations.

The second one is a little less typical, but I think relevant given what facilities and healthcare systems are facing with respect to climate change and changing threat patterns for wind and flooding and heat and et cetera. Any comments or thoughts on these two (accepted) measure concepts?

Margaret Weston: Okay. I think we can move on.

Paul Biddinger: Yes, I'll take these. We have three more rows here. Obviously on existing facility infrastructure. One relating to Community Infrastructure, such as roadways, utilities, things outside the hospital, or healthcare system.

Secondly adaptations that can be necessary or that can be performed to adjust facilities. And the third is encompassing codes and standards and sort of a basic process of evaluating damaged structures and responding to it.

Any comments on these? On these measure concepts?

Scott Aronson: This is Scott Aronson. Not as much a question on this. I just had a comment. In the end, when we look at, you know, the outcome, and that next step that takes place here. How far do we want to go with infrastructure? I mean a hospital obviously can't get through a 0% failure point on there.

But a lot of things, you know, a hospital has got to know through a vulnerable assessment and others, how - where all those break points are. But I guess, is there - is there a threshold that gets established as to what that failure point can be? Investment threshold or something? And I know that's beyond our discretion right now. But are we looking to take that with a next level metrics at some point as to what is an acceptable failure level? Or is that not something that would ever come out of a group like this?

Paul Biddinger: So, I'm going to offer - this is Paul - a half comment and then I expect the NQF Staff and Jesse and others will have a lot to add to this - but obviously right now we're in the measure concepts. And certainly, the measures follow, which is documenting where people are.

I think what you're talking about, if I understand it correctly, is you know, standard setting basically. You know, sort of, what's the pass-fail limit on

many of these things. And I definitely think that is, sort of, for another different audience or for a different entity to do. But I think it's actually an extremely interesting and important question. I don't know, NQF folks, do you want to add to that.

Margaret Weston: Yes, Paul. Thanks for taking that. And yes, it would be a different entity. Because as far as, sort of (our word) goes, this is the measure concepts phase and then it would go to some other entity that develops the measures. And that would be separate from measure development. That would be threshold setting. So, yes.

Paul Biddinger: Okay, thank you.

Jesse Pines: But I think, this is Jesse here - I think ultimately that would be where this would go - would be very specific thresholds for these measures, where it would be clear what is good and not good performance.

Paul Biddinger: Yes, but that's definitely an interesting question. I appreciate that. All right. Do we want to move onto the next page?

Margaret Weston: So, the next Subdomain areas. I know the NQF Staff had asked if given the time that we have left, if we might move to the next step area? Are the people on the committee comfortable with reviewing some temporary facility infrastructures through the remaining measure concepts and sending their feedback and comments into NQF so that we could really move to the next steps and get some time talking about what that really looks like.

All right. If there are no objections, if we can move to the next steps. Jesse, did you want to talk on the next step and give a little feedback about that?

Jesse Pines: Sure. So, maybe what we could do so, our overall goals here are to really sort of outline the, you know, where we go after this. And to be ideally as specific as possible with recommendations for, you know, for future efforts by NQF and other groups. And, you know, basically being very specific about, sort of, who does (next) and how do we take things to the next level here?

Can you go ahead and put up the - do we have a draft of the next step's action we can put up for folks? Poonam?

Margaret Weston: Yes, we're putting it up now.

Jesse Pines: Okay, great. Thanks.

Poonam Bal: Hey, Jesse. Why don't you start discussing it and we are pulling it up? It'll just take a minute for the system to show.

Jesse Pines: Okay. Sounds good. Let me just get to it here in my report. One second. Okay. Over here. Okay, so you know, I think what we've heard a lot about on this (haul that) going into the measures in detail and, you know, sort of wordsmithing this long list of measures -- I think one of the big next steps we would need to do - and we may not get to it within this group - would be to help prioritize some of these measures.

And then ultimately, you know, have, you know, groups, (HHS, like ASPR) you know, start to invest in the development of those high priority measures. So, like people have said earlier, NQF does not measure, you know, does not develop measures. Other groups would need to go through some of the measure testing and specifications and get to the point where something could be reviewed by an NQF Standing Committee.

You know, so I think certainly through this process, we have identified several measures that are, you know, potentially could be taken to the next step. You know, I think one of the questions I would have for the committee here is, how we want to prioritize what we have?

And specifically, you know, we have a lot of microconcepts here, you know, that sort of take a very zoomed in view of readiness. But can we, sort of, step back a little bit and think about, you know, what are some of the measure that may be able to sort of encapsulate, you know, multiple measures?

I don't know if Dave Marcozzi is on. I don't think he was on the roll call. But we had had a conversation about, you know, some higher-level concepts, you know specifically, you know, the concepts of business continuity, you know, which encapsulates a number of different measures together.

And also, the concept of, you know, a hospital really being able to, you know, sort of, give a good accurate assessment of the number of patients that they could take at any particular point. So, immediate bed availability.

So, anyway, let me go ahead and stop there and get your feedback on the Step 1 which is up there, which is one identifying high priority measures and how we do that.

Paul Biddinger: Steve, I see you have your hand up.

Steven Krug: Yes, I mean I think to what you just said. The place to start, I mean, there're (too) numerous opportunities here, but Step 1 is to begin to evaluate and measure, identify gaps and seek to improve. I think the capacities and the capabilities - capacities and capabilities are different.

But I think that from a Health Care System Perspective, that that would be one of the earliest places, if I was ruling the jungle, that I would (ask) the institutions - both those that are getting funding and those that are not getting funding - to look at what they can do and begin from a capacity and a capabilities perspective.

Jesse Pines: And when you say that, does that mean, you know, like I said earlier, this capacity and capability in real time or, you know, or just in general? So, you know, on a Saturday afternoon, there's a bus accident or, you know, and you get a call to the ED and you know, how many patients can you take now?

You know, often that question is, you know, someone sort of making things up and, you know, well maybe we can take this many patients. Or capacity you can build this more broadly in terms of staff that you have to take care of, you know, populations and disasters.

Steven Krug: Right, well it's - to your point I mean, it's a great place to start. Not that I'm wishing (there would be) bus accidents, but a bus accident or a smaller disaster (unintelligible) rival (to match) a bus accident occurring outside a small hospital would be a big disaster.

Yes, but looking at it broadly, so, again, it's been observed that institutions do practice and they practice in limited settings. They may just (trust) the Emergency Department and the event never goes beyond that. So, it's understanding what would be necessary to do something more than just take a brief hit from a bus accident and all of the components. All the domains that are in this spreadsheet that really need to be evaluated.

And maybe all of that in its totality is overwhelming. But institutions need to think bigger then how many of them are currently today preparing for disasters.

Jesse Pines: Other thoughts. That's, I think definitely true. Other thoughts on how we can prioritize and, you know, sort of, you know, think about coming up with maybe a more limited set of measures that would be, you know, be seen by the folks who are acute medical officers and folks in that category, who could say, okay, you know, we want (to) start operationalizing some of this.

You know, you gave me a list of, you know, measure concepts that's very large here. You know, where should I start?

Steven Krug: Yes, I want - this is Steve again. I don't want to dominate the conversation, but that's part of the problem. I mean, there's this terrific list of measure concepts and there is - if it's current form or after it's been tweaked, it will be overwhelming by the average reader who is thinking about how this applies to their institution.

So, I really do think that there needs to be a translation here in terms of where the focus should start. What are the first steps? And some of these things are 101 issues to test and some of them are, you know, 201 or 301 level courses.

Jesse Pines: Okay. Other thoughts about prioritization. Number two then, is trying to figure out where we are now. And I think this is, Steve, to your point, getting to what, you know, really the sort of assessment of capacities and capabilities around readiness at the level of the community. So, you know, I think that is something that certainly does not exist now.

So, how do we think about, you know, of doing some community readiness assessments, sort of seeing where we are today. And then, you know, potentially developing a cured system of hospitals, once we sort of figure out who has what for disaster? So, let me stop there and get people's reactions on that.

Margaret Weston: June, I think your hand is raised.

June Kailes: Yes. Can you hear me?

Jesse Pines: Yes.

Margaret Weston: Yes.

June Kailes: Okay. Yes, I think no matter how long it takes (unintelligible) occurs, (we have) all begun to see (unintelligible) happens. (Unintelligible).

Jesse Pines: June you're breaking up a little bit.

June Kailes: How's this?

Jesse Pines: Yes, that's better.

June Kailes: Okay. And you know we like (unintelligible) documents (unintelligible) but, I think a lot of people look at it in its final current form now. And maybe there needs to be a small section on where to start? You know, what do you do with this now? And how do you begin to think about it in doable small pieces and maybe make some good practice suggestions like, you know, creating a team or assigning parts to different staff with different responsibilities that make sense.

You know, doable small steps that can be achieved over time, because it is overwhelming. But that should not be the excuse. So, I think we need to help it along by making some suggestions on how to use it now it it's whatever, final form. It looks like, and what to expect of this in the future. Does that make sense?

Jesse Pines: Yes.

Margaret Weston: You know, that's great June. That's actually what we really like to focus on in these next steps is, you know, what are those steps that you, you know, the committee thinks should be done so that, you know, someone can use this framework and move it along. Or, you know, make it something that they can digest.

June Kailes: So, how do we do it. I mean, in a system, how do they assign it? How do they break it down to make it work for them, no matter what system they are?

Jesse Pines: Right. I think that's the question. Is the - you know, how do you sort of take wherever we are now and operationalize, you know, some steps, that, you know, how various entities can take to become more ready and how do we assess that? And I think that's - I think that's absolutely right.

I don't know, do you want to see what folks think about this concept of a tiered system and whether or not that resonates? I don't know, Paul, or Margaret, if you guys have thoughts about that specific concept and whether or not we want to include that?

Margaret Weston: So, are you - the community level assessments on - when you speak to that, I mean, there's a lot of community level assessments that are currently

happening out there. Are you - when you're framing this from a next step perfected - are you asking about tiering based on the measure concepts that we've developed or are you looking at it more from a global perspective and then applying the measure concepts to those tiers?

Jesse Pines: Yes. I think the latter. It would be to sort of take this framework and using some of these measure concepts as, sort of tools in terms of how you would, sort of, do an assessment. You know, do you have the ability to do these sorts of activities? And then sort of looking at that from a community level. You know, not just hospitals, but other entities and, you know, who really - who's really responsible.

I mean that sort of gets, you know, gets into Number 3, which is - it's really about sort of defining roles and responsibilities. I mean, you have, you know, the large, sort of day-to-day Healthcare System that, for the most part, is run by private entities.

And then you also have these public entities out there and there's, at least to me and, you know, maybe not clear distribution about whose responsibility it is to be ready. I mean, there are certainly, you know, regulations about what certain healthcare needs have to do.

But they're sort of very specifically defined roles and, you know, to sort of bring the public and private sectors together on the same page. Which, you know, which I think in some communities exist and some communities does not.

Margaret Weston: Okay. So, I would say, within that system of community assessment, really to be able to better define what the roles are and how that looks from the overall assessment, I think that because we have created so many measure concepts, I

don't know if there is a feasibility index or feasibility scale that is already out there in existence to be able to look at. Whenever you have a measure that you're going to have to collect data on and analyze across multiple entities.

Is there a way to actually look at feasibility across entities? I don't know if that could be developed as part of this work so that that prioritization process could be better steam-lined. But I think that those two things go hand-in-hand.

Paul Biddinger: Just…

Jesse Pines: In prior - yes, go ahead Paul.

Paul Biddinger: Sorry Jesse. I think, you know, the thing I would add is harkening back to some of the conversations we had relatively early in this project, that I think, you know, is really, really important that measures, generally speaking, are applied to the people that have the appropriate responsibility and authority to make changes. That, you know, to hold any level of entity or system accountable or responsible for something that they're not empowered to change obviously, is not going to be a great system.

And I think, you know, what we know to be true, I think all of us on the call now, is that there certainly are gaps. But there are areas, exactly as you said Jesse, where, you know, the Healthcare Infrastructure is generally speaking private. And then the need to unify multiple different private players to create certain community capabilities, you know, individual private entities don't have either authority or funding or responsibility for.

But then when you get to the governmental authority, public health authorities, that do have some degree of coordination authority, they either

lack the expertise or are often unwilling or unable to come in and step in on the clinical side to coordinate, say, you know, the degree of search, trauma care search, pediatric care, burn care, whatever that is.

As I think we're going to actually identify some gaps when you look at some of these community measures where there isn't a clearly, defined authority and responsibility there. I think ultimately, we need to call those out and identify then, you know, what to do with that data.

Because measuring that gap will be one thing, but then trying to figure out who's responsible for addressing it will be, I think, a much harder challenge.

Jesse Pines: Yes, I completely agree. You know, trying to - how do we get to where we are now to, really sort of align the public and private sectors to agree on who's responsible for what? And, you know, specifically there's then - you know, for example, you know, some reticence on the part of the private health system to share, you know, data on - you know, not just capabilities, but on capacity and how many beds do we have now? You know, could that be shared into a common system that could be used in the public sector to figure out where people need to go during a response?

Paul Biddinger: Jesse.

Jesse Pines: All right. Any other comments on Number 3? All right. Okay. Number 4 is, you know, I think, sort of the next generation step where, you know, once we have specified measures that are in practice and, you know, thought to be important and feasible, it would be to start thinking about how we tie those to payments. And, you know, currently the organizations received payments based on measures such as readmissions.

And can we think about letting this measure, sort of, in the same category of, you know, how do we tie performance on readiness to the payments? And also, actually, there was a sort of separate comment that I didn't address earlier on the prioritization side. I think, Margaret, you'd said for, you know, in terms of prioritizing, you know, which of these measures might be best to sort of take to that level?

You know, ways that we've done that in the past for similar projects have been to, you know, rank measures on importance and feasibility. So, feasibility being the, you know, sort of key component on that. So, that would be one way. I'm not sure we'll have enough time to do that in this particular project. But, you know, take what we have now and to have a ranking exercise of importance and feasibility.

I think, you know, it would be very responsible of us as a committee, as a group, to try and provide some guidance on where we think - or action is most urgently needed and most likely to be successful. But, you know, among all the measure concepts on this list, obviously, they're definitely not equal in terms of their potential impact on overall readiness. And so, I think it would be important to try and give some concept of, you know, at least among the group that has worked on this, where we think the most important next step on individual measure work is - should be focused. (Other thoughts on that?)

Okay. And the last one here (unintelligible) general thought of that (unintelligible)

Margaret Weston: Oh, Jesse, I think you broke up. We cannot hear you.

Jesse Pines: Okay. Let me - let's hear - is that better?

Margaret Weston: Yes.

Jesse Pines: Okay. So, Number 5 is Alignment of Government Stakeholder. So, there are currently a variety of governmental entities that are, you know, that sort of play a part in readiness and response. And, you know, these are groups that. I think, you know, could be potentially better coordinated sort of similarly on the private side.

You know, Health Systems are not necessarily talking to one another about, you know, how, you know, let's say competitive Health Systems are, you know, if they collaborate and be ready. I think, you know, still to some degree, that exists - you know, the silent approach on the government side. So, I think an important next step would be to try to figure out how we can unify some of the priorities when it comes to readiness across these various entities. You know, specifically ASPR, CDC and others.

Margaret Weston: Steve, you got your hand raised?

Steve Krug: Yes. You are correct. There is a lot of intersection and a lot of overlapping responsibility and less than ideal collaboration. That's true in all sectors. Not just on the government side. I'm going to be slightly bold and controversial but, it would be even better - in addition to the agencies getting together and coordinating their efforts - it would be really useful if they also - I mean, fine, don't tell us talks - you know, don't tell us secrets about what a certain (cult) is planning to do next month.

But they should be bringing the private sector to the table for these conversations. Because in the end, the government's not pulling it off on their own. And I think if there was better awareness of what the reality is - who does what and what the capabilities are - I think we would be - a lot of the

folks would then have to do this at the local or regional level would do a better job.

Jesse Pines: That's a really good point and something that, you know, for those folks are okay with and we can certainly include that here. Great point. Other comments? Thoughts?

James Paturas: Yes, the only - this is Jim Paturas. The only thing I would say to all of these comments - and I know you'll appreciate this Paul - is it really does speak to some of the other work being done with the (RDHRS) and you know, how do we really all try to play in the sandbox together. The capabilities are there. It's the relational issues and some of the technology issues and some of the process issues that really, you know, are paramount to helping make that work at a regional level.

Paul Biddinger: Yes, obviously I strongly agree.

James Paturas: I knew that.

Jesse Pines: I know we're sort of nearing the end here. You know, I do want to give you folks the opportunity to, you know, if there are other next steps that come to mind, you know, please let us know. We're, you know, if you think of something after we hang up, just send one of us a note.

But before we end the discussion here, are there any final comments or any other thoughts on next steps that we could include? Okay. Then let me turn it over to Paul or Margaret.

Paul Biddinger: Actually…

Poonam Bal: Okay. This is actually - I'm sorry, two seconds. So, again, we just want to reiterate that the next step is an integral part of this report and we do want everyone to be comfortable with any of the suggested next steps here and all the discussions that we've had. So, please let us know if you do have any more again.

Please take time to read the report in its entirety and then send us all of the information you have by Friday of next week. Which is I think, May 17th. All right. I'll turn it back to Paul and Margaret.

Paul Biddinger: I don't know that I have too much more to add other than to really say thank you to everyone. I think this certainly is a long road. It's a complicated project and it's, you know, there's been a lot of hard work. But I'm just so very grateful for all the comments. You know, what Margaret said at the very beginning is really true.

All the perspectives, all the input, all of the thoughts. At every stage of this process, including very much today, is really welcome. And so, I just wanted to say thank you to everybody for participating and sticking with all of us.

Margaret Weston: I, and I echo Paul's comments. It has been a long road and I just thank each and every one of you for sticking with us and helping us step-by-step move this along.

Poonam Bal: So, we're going to do Public Comments now just for the - we're going to allow for any public comments. Are there any public comments on the phone? And, also if you're in the public, you can chat us your comment as well. And we'll just give them a minute to make sure they can unmute their phones or send in their chats.

Operator: The conference has been unmuted. The conference has been unmuted.

Poonam Bal: So, we don't have any public comments in the chat and we don't have any in the phone. So, what I'll do at this point is, definitely take a moment to thank our co-chairs. They had the herculean task of sort of corralling us along, as well as our committee for all your input, thoughts, edits.

And we're so looking forward to more edits by next Friday. Again, next Friday which is May 17th. Because afterwards, it's after that period, it's going to go into our publication process and at that point no changes can be made.

That, and of course, my teammates here at NQF - it's been a very interesting project topic wise, but also with all these Webinars and sort of, making sure all the edits are made and all the materials are prepared.

And definitely, finally, our CMS ASPR colleagues for giving us the opportunity to do this work. And with that, I'm going to see if our CMS or ASPR colleagues would like to say a few words as well.

(Will), (Brendan), (Matt)? Are you guys on mute?

(Matt): Oh, hi. This is (Matt). Can you hear me?

Poonam Bal: Yes, we can hear you.

(Matt): Okay. I was (unintelligible). I (would say on) behalf of ASPR that we really appreciate the hard work that all of the members have done into doing this. And that once the report is finalized, we will take the report and we will get it up to the ASPR Leadership and all of your input will help us to - on our next steps as well. So, we just wanted to say thanks again for all of your help.

Poonam Bal: (Unintelligible)? No. Okay, well then again, as far as our next step goes there're two next steps. The first is please send us, again, any thoughts, comments, edits, to us by next Friday, May 17th and the final report will be out June 13th. And we will send you all an email once it's out and with that, we can adjourn for today. Thank you.

Margaret Weston: Thank you.

Jesse Pines: Thanks everyone.

Paul Biddinger: Thank you.

Debjani Mukherjee: Bye.

END