NATIONAL QUALITY FORUM

Moderator: Health Care System Readiness
September 12, 2018
1:00 p.m. ET

Operator: This is Conference #8367508.

Female: Hello.

Operator: Welcome, everyone.

Male: Hi.

Operator: The webcast is about to begin. Please note today's call is being recorded. Please stand by.

May Nacion: OK. Good afternoon, everyone. This is the NQF and welcome to the Orientation Web Meeting for the Healthcare System Readiness Project. We'll just start off today with an overview of the agenda. First, we will do quick staff introduction, and then turn it over to Jack Herrmann, from the Assistant Secretary for Preparedness and Response, also known as ASPR, who is one of our partners in this work. And then we'll continue on with more in-depth introduce as well as an overview of NQF in general, the project, public comment, and next steps.

Next slide. These are the staff members who are on this project. I will go first and everyone else can feel free to introduce themselves. My name is May Nacion and I'm the Project Manager for this project.

Poonam Bal: Yes. I'm Poonam Bal and I'm a Senior Project Manager on this project.

Debjani Mukherjee: Hi, I'm Debjani Mukherjee. I'm one of the senior directors on this project.

Kyle Cobb: And hello, everyone. This is Kyle Cobb and I am also a senior director on this project. And (Jesse Pines) is …

(Inaudible)

Kyle Cobb: We do request the folks to mute their lines so that we don't hear the background noise. Anyway, (Jesse Pines) will be working and has been working with us on the project. He is not going to be here today with us but certainly is participated. So back to you, May.

May Nacion: OK, thank you. And then, we'd also like to introduce our additional partners from ASPR, who are the subject matter leads for this project. And they are Brendan Carr, (Jessica Couglard), (Matt Cognell), all right.

We'll go on to the next slide. So this slide is listing of our current committee members. However, we are going to hold off on the introduction after listening to Jack Hermann's presentation. Jack is the Director for the Division of External Stakeholder Engagement in ASPR at the Department of Health and Human Services. Jack, I'll turn it over to you.

Jack Hermann: Great. Thanks so much and good afternoon, everyone. Certainly, with Hurricane Florence looming off the coast of Southeastern US and Mid-Atlantic seaboard, the work of this committee could be anymore timely and relevant, so thank you all for being part of this initiative and thank you for having us as a partner.

On behalf of Dr. Robert Kadlec of the ASPR and Dr. Kevin Yeskey, the Principal Deputy, Assistance Secretary, I'd like to thank you for giving ASPR the opportunity to speak briefly with you this afternoon. And as you heard, I'm Jack Hermann and I'm ASPR's Director of External Stakeholder Engagement. Can we take the next slide, please?

So as many of you maybe aware, Dr. Kadlec and ASPR have four overarching priorities, providing strong leadership, sustaining robust and reliable public health security capabilities, advancing an innovative medical counter measure

enterprise, and building a Regional Disaster Health Response System. One that ensures the nation's healthcare system is ready to meet the needs of the American public during our most challenging times.

Over the past year, Dr. Kadlec has taken the opportunity to share with Congress, professional organizations, ASPR led external stakeholder listening sessions and many other public venues, his vision of a Regional Disaster Health Response System. And he describes that as a system being built upon that nation's existing trauma system and healthcare coalitions that have been created through ASPR's Hospital Preparedness Program. That and a system that addresses gaps in coordinated patient care to meet the needs of the American public during times of system stress. So next slide please.

Certainly at ASPR, we recognize that healthcare in the US is primarily delivered by the private sector. And on a good day, the system is stretched to or beyond capacity on many areas of the country. And so, preparing our nation's healthcare system to surge in response to disasters and other emergencies presents myriad challenges, and especially in light of today's current threat environment.

Currently, as we look at the 21st century threats that we face, casualty estimates related to those potential threats exceed the capacity and capability of our nation's current healthcare system. And preparing that system for disasters and other emergencies may well encounter to standard business practices of medicine. Disaster health system readiness by definition presumes that such capabilities might exceed actual day to day needs and thus might be viewed as highly inefficient and inconsistent with standard business practices that emphasize just in time solutions in the existing reality of functioning at an operational capacity at all times.

Additionally, Healthcare Preparedness and Response as we know it exist today, it's fragmented and uncoordinated across the jurisdictions. Many of you on this committee intimately know that. Hospitals don't routinely plan, train or exercise together. Communication both outside of and during disasters and other emergencies may be limited and fraught with gaps. And

obtaining situational awareness of healthcare operating status during disasters is challenging in real-time.

Finally, ASPR's key programs to enhance medical surge capacity, many of you know the National Disaster Medical System in our own Hospital Preparedness Program require updating to meet the current challenges and threat environment. Next slide.

The image you see here, while it is notional, to some extent illustrates the Regional Disaster Health Response System concept in what we're trying to build across the nation, and does kind of emphasize that partnership with the private sector.

First, we need to ensure that our front line sources of healthcare are hospitals, trauma centers, pediatric care centers, community care facilities are well-prepared and have the capabilities, they need to meet the health related needs of those impacted by the disaster. But we also need to focus on ensuring the right assets and strategies are included in healthcare coalitions, and eight local facility-based on emergency plans.

In addition, we need to ensure that all regions across the country are capable of providing specialize medical expertise and equipment to populations affected by disasters and other emergency. But not every facility can offer the same level of specialize care. But we still need to ensure that such care as either geographically located or available in other ways so as not to compromise the patient care, the clinical patient care that's needed during those incidents and ensure that we are protecting the lives of our patients.

At ASPR, we recognize that Healthcare System Readiness will require engagement and collaboration with the private sector. Recently, we sponsored a workshop at the National Academies of Sciences, Engineering, and Medicine which actually focus on aligning incentives so that the private sector healthcare systems would be more willing to engage and ensuring that they have the capacity to meet the needs of the American public during times of crisis. The report from that workshop is available on the website of the National Academies Press, if you haven't seen it yet.

Some of the workshop participants also suggested during that convening, that quality measurement is one means by which to engage the healthcare system. Areas such as patient safety, healthcare quality and the efficient management of chronic conditions have become priorities for the healthcare sector, thanks to the development of quality framework and quality metrics. And it's our hope that the effort you're undertaking will highlight the importance of readiness.

Hopefully, the work you'll be engaged in feels like a natural next step for you on the committee to take. And I hope you share in our common goal to advance the nation's healthcare system so that it is ready and prepared to take care of the lives of its patients, both during day to day emergencies as well as in those rare catastrophic events.

A framework for measuring the readiness of the healthcare system will create a shared incentive within the healthcare community to continually improve coordination across stakeholders.

In closing, we would like to thank again, our colleagues at the National Quality Forum and our friends at CMS for including us in this partnership. I wish you the best in this initiative. Thank you.

Debjani Mukherjee: May, are you still there?

May Nacion: Yes, sorry, I was on mute. Thank you so much, Jack, for that great introduction regarding ASPR's work. Turning it back to introduction, I also like to note that there are three more proposed committee members who are undergoing to commenting process and we'll add their names onto this list once that is complete.

But to start with the introductions, as we call your name, if you can please briefly introduce yourself and add in one to two sentences about one of the three questions regarding readiness that we have prepared. And so I will start in alphabetical order.

Poonam, if you'd like to tee up the question so that everyone can see them.

All right, Scott Aronson?

Scott Aronson: Well, this is Scott Aronson. I'm actually just coming out of the major disaster exercise, so we're running into this. But I am a Principal at Russell Phillips and Associates, RPA, and I also an international practice leader with Jensen Hughes for the Disaster Management focusing on hospital evacuation and nursing home evacuation in a catastrophic surge capacity.

So, what does it mean to be ready for disasters? As we get into this, most of the work in here is identifying the health system capabilities and really looking at their ability for command and control in a lot of the disasters. And so that's one of our starting point that I like to get into, and then really moving into their interaction and communication with all the community partners. So the coalitions are a great framework and it has to built upon to enable the home health all the way up to the hospitals to work effectively together.

May Nacion: OK, thank you. Sue Anne Bell?

Sue Anne Bell: Hi, I'm Sue Anne Bell. I'm an Assistant Professor at the University of Michigan in the School of Nursing. I'm a researcher that studies how older adults adapt to and respond to disasters. And then, I'm also a clinician where I respond to disasters, mostly through the National Disaster Medical System where I'm a nurse practitioner.

To answer the question, I'm here representing the Emergency Nurses Association so the biggest challenge to achieving readiness for my organization, ENA, is we have 40,000 members who work in a variety of hospital settings throughout the United States and internationally and achieving consensus is a big issue. But also, we have issues of organizational capacity, time and funding that are barriers to readiness.

May Nacion: OK, thank you. Paul Biddinger?

Paul Biddinger: Sorry,(just took a second to get off mute. It's Paul Biddinger. I'm the Director of the Center for Disaster Medicine at Massachusetts General Hospital and

Director of the Emergency Preparedness Research Evaluation and Practice Program at the Harvard School Public Health, also an emergency physician.

I guess I'll take the third question. And I think – I guess my take on what it means to patients for the local providers to be ready for disasters means that no matter what the events is that they can expect access to care during and after the event that is informed by best practice and evidence so that they have maximal chance of survival and a healthy recovery.

And I think obviously, it's been my experience, so that is certainly unfortunately inconsistent. And one of the great challenge is to continue primary care, specialty care and make sure that the disaster planning and disaster care is evidence informed.

May Nacion: OK, thank you. Emily Carrier?

Emily Carrier: Hi, I'm Emily Carrier. I'm an Emergency Physician by training, also Health Services Researcher and have done policy at the state and federal level. Currently, I'm working at Manatt Health and we do work with providers and also with states on Medicaid Delivery System Reform efforts.

And I'll also tackle question three and I think I'll give a similar answer. To me, what it would mean for patients for both our local healthcare providers and also in their payers to be ready for disasters would be that all the tools that their providers and payers have collaborated on building and paying for to give them good care, don't stop working just because the disaster happen.

May Nacion: OK, thank you. Cullen Case?

Cullen Case: Hi, this is Cullen Case. I'm the Program Manager for the Radiation Injury Treatment Network. And I think that for question three, kind of comes to mind is that the efforts are done in advance that result in the seamless care for those patients. So, those efforts are behind the scenes that we don't really see all the work that's being done to them.

Everything is moving smoothly regardless of the Hurricane Florence approaching or has hit recently the powers there, all the systems there, the staff are there. All the resources and logistics are there. Thank you.

May Nacion: OK, thank you. Katelyn Dervay?

Katelyn Dervay: Hi, everybody. My name is Katelyn Dervay. I am the Emergency Medicine Pharmacist at Tampa General Hospital and I'm also the Pharmacy Liaison for Hospital Disaster Committee.

I'm also serving as the representative from the American Society of Health System Pharmacist, which is a group of pharmacist both ambulatory care and the health system in the hospital of about 40 – over 40,000 members. I'm also an Emergency Medicine Residency Director for Pharmacist and work to develop other pharmacist skills in that area.

For the question, seeing that I was the only pharmacist on this committee, I kind of focus on challenges within the organization, and for us with medications, it's making sure both during and after medications are available for our patients considering operational things, such as refrigeration without power, expirations and rotations of caches. And also while providing these medications still making sure they're safe and easily accessible to our patients.

May Nacion: OK, thank you.

Poonam Bal: May, just one second before we keep going. I just want to remind everyone that these are individual seats on the readiness committee, you've been selected as subject matter experts. And while you would definitely bring a point of view from the organizations that you are part of and take part in, you know, it really should be you're representing yourself, not as a fixed organization. And I just want to be – make sure that we're clear about that as we continue with introductions and now we're going to be working with May. So, thank you. May, go ahead.

May Nacion: OK, thanks. Alexander Garza?

Alexander Garza: Yes, hi. This is Alex Garza. I'm an Emergency Physician by training, spent sometime in the army and also in Homeland Security. Now, I'm the Chief Quality Officer for a mid to large healthcare system in the Midwest called SSM Health.

So my answer to a question would be, what does it mean for an organization to be ready for disasters? And for us it means being able to be functional during at time of disaster. And so that means having capacity, capabilities and planning to prevent any sort of systems failure.

May Nacion: OK, thank you. Jennifer Greene?

Jennifer Greene: Hello, I'm Jennifer Greene. I'm a licensed professional counselor and I work as a Project Manager for one of the seven managed care organizations in North Carolina. I also have a background in transportation and logistics. And so, I've had some experiences with the way that trucks run the road at the time of 9/11. So there's a slightly different perspective in this area that I can bring. I serve to bring integrated care efforts to our community centers for the continuum of care and crisis response.

With respect to the questions that you presented, from a behavioral health standpoint, one of the biggest challenges to achieving readiness for disasters in the organizations or the providers we support is that our resources are often confined to certain areas that the people that are service supported could be statewide or outside of that regions to being able to manage their behavioral health needs when they are hundreds of miles away from their normal natural supports and resources.

May Nacion: OK, thank you so much. Angela Hewlett?

Angela Hewlett: Hi, this is Angela. I am an Infectious Diseases Physician at the University of Nebraska Medical Center in Omaha, Nebraska. And I'm the Medical Director of the Nebraska Biocontainment Unit. I'm actually here representing the Infectious Diseases Society of America.

And I guess my answer to the challenge to achieving readiness is just that maintenance and preparedness aspect in the fact that, you know, it's easy to

have a facility. It's hard to maintain that facility, maintain that team capabilities and also that funding stream. Thank you.

May Nacion: Thank you. Thanks. Feygele Jacobs?

Feygele Jacobs: Hi, everyone. This is Feygele Jacobs. I am presently working at the RCHN Community Health Foundation and so I'm going up frame my answers in the context of the works that we do with community health centers nationally and most recently with – based on our experience with community health centers in Puerto Rico.

In response to question three, what does it mean for patient that are local healthcare providers to be ready? Well, you know, based on some of my recent experience, it's really that those providers have the capacity, not only to serve the people whom they've always served, but potentially new populations in their area and to provide services not only that they're historically provided, but new services that present as a result of the catastrophe. And that's being, you know, something that we've seen time and time again. But certainly that point has been driven home, you know, for us most recently in Puerto Rico. Thank you.

May Nacion: OK, thank you. Mark Jarrett?

Mark Jarrett: Hi, good afternoon everybody. I'm Mark Jarrett. I'm the Chief Quality Officer and the Associate Chief Medical Officer for Northwell Health, a large multi-hospital health system in the metro New York area.

I have to admit, I'm a rheumatologist not an ED physician, but I've been leading the clinical side of our emergency preparedness at the health system for a number of years. And also, I had a wonderful experience of dealing with Irene and Hurricane Sand, Super Storm Sandy. So, as well as obviously the New York challenges that are always going on.

And I would kind of echo what Angela said for number, it's sustaining the training and the teams, especially if you're doing, you know, if you have multiple potential disasters incurred based on your HBA and how do you get

the time, the effort and the money to maintain the interest and the true skill sets and competencies of your special teams.

May Nacion: OK, thank you. June Kailes? I think June is unavailable for this meeting, but I think somebody is able to speak for her.

OK. We'll move on to Matthew Knott?

Matthew Knott: Hello, everybody. This is Matthew Knott. I'm actually a Division Chief of a Fire Department and have a lot of experienced with hospitals, prior to being in the Fire Department and after also worked as a domestic preparedness specialist for a large regional hospital system and did training and exercises throughout the – throughout most of the country. Also involved with the response to Hurricane Katrina and then also to Irene up into Connecticut.

So, I think the biggest challenges that we see with healthcare organization is just, you know, is basically just the need for the day-to-day operations that still occur, but yet still trying to pull in all of the needs for disaster response. So, you know, it's enough of a challenge just to meet daily needs and daily operational needs but let alone preparing for disaster. So I think that's the biggest challenge that we see achieving readiness for healthcare institutions.

May Nacion: OK, thank you. Stacey Kokaram?

Stacey Kokaram: Good afternoon everyone. I'm Stacey Kokaram. I am the Director for the Office of Public Health Preparedness at the Boston Public Health Commission. So in addition to having several years of experience working in public health, I have done a lot of work with our local healthcare coalition and our response organization of that coalition and also in terms of response to emergencies through our emergency support function (aid) lead for the City of Boston.

So in terms of the questions, I'm going to echo what a lot of other folks have said around question one. So the biggest challenge for us is capacity, so thinking about everything that contributes to a person's health and well-being, especially after disaster is very broad. So that kind of thinking and that kind

of readiness really requires this type of system that we're thinking and also this partnership in order to achieve that.

May Nacion: OK, thank you. Steven Krug?

Steven Krug: Hey, this is Dr. Steve Krug. I apologize for the background noise. I'm a Pediatric Emergency Physician. I work at the Ann & Robert H. Lurie Children's Hospital of Chicago. I am the Chair of the American Academy of Pediatrics Disaster Preparedness Advisory Council. And I have the privileged of working with a variety of folks and agencies in our efforts to improve readiness.

You know, the fundamental answer to question number two, we'll hopefully be supported by the work that we're going to do because you can't improve what you don't measure. That's why I think metrics are really so important.

You know, from my perspective and, again, while I'm interested in the entire population and there's tremendous overlap in terms of needs and process, obviously a lot of my work has been focus on the pediatric population. And the biggest challenges is really – well, we're actually beyond recognizing that, you know, kids are out there and have different needs. It's all about them getting organizations ready, both large and small on a – really on a day-to-day basis because that sort of the foundation of a system.

And as I think Jack Hermann pointed out, the systems are already stretched to begin with, so it's tough to add additional capacity and it's also tough to ask institutions to care for kids that ordinarily send them some place else but may not be able to do that during a public health emergency. So, that's really been our biggest challenge.

And frankly within the academy, I think our largest challenge is, frankly, working with our primary care physicians. They constitute the largest component of the academy, 60,000 members. And getting them to be ready and certainly folks that live on the coast are doing that right now. But, that's really so important.

And just to reiterate one of the points that I'm sure one or more people made, I mean, for our patients, it's so important for the healthcare system in its entirety to be prepared because that's such a fundamental part of the resiliency that we're trying to achieve.

I mean, disasters – hurricane season is going to come next year as well, whether we like it or not. And if we can become both better prepared, but also become more resilient, we'll do better. So, again, I'm really looking forward to participating in this process. Thank you.

May Nacion: OK, thank you so much. Nicolette Louissaint?

Nicolette Louissaint: Hi, my name is Nicolette Louissaint. I am the Executive Director of Healthcare Ready. We are a public-private partnership originally formed as a coalition of members across the healthcare supply chain to work on behalf of the private sector to make sure that there was a continuous partnership with the public sector, both before, during and after disaster. So, that is the advantage that I bring to this committee.

I would say that from the – looking at the questions, I think I should answer on behalf of the coalition that we represent and not just our organization. I think one of the biggest challenges is being able to hear a common operating picture.

One of the pieces that we continue to see as coordination even across public-private partnerships has improved is what it really means to have a common operating picture and how do we work together on not just having a readiness posture for the continuous and likely events, but really thinking about that all hazard to service.

So, not just knowing capabilities of particular organizations, but some of their vulnerabilities, which is information that typically can be more difficult to share and how we should work together to support each other during these events.

And I'm just going to – I think that kind of answer the second question. So I'm going to get to third question because for us that's really our ultimate

mission is making sure that patients have access to healthcare medicines during disaster. And for us what that really means is thinking about the entire supply chain.

So, someone early made the comment about the pharmacist and the rule of pharmacist during disasters and I think that's incredibly important. But as we're seeing that there are many patients that may have multiple comorbidities, we'll be very close to becoming medically fragile are reaching criticality during an event, thinking about how the entire healthcare system and all of the capabilities beyond hospitals looking at insularly care.

Another forms of practitioner that can be useful during events can work together to both share information to make sure that patients have access to resources during events is incredibly important to us. Thank you.

May Nacion: OK, thank you. David Marcozzi?

David Marcozzi: Hi, good afternoon. I'm David Marcozzi. I'm an Emergency Physician. I work in the policy space and the operational space for some time. (Inaudible) military and right now chiming in from the military location. So I may have to hop off. I look forward to be contributing to the group.

I would just say that as far as thinking about how a health system prepares and what preparedness looks like, I think that it's fine and I look forward to NQF's work in this space about putting some requirements, at least an intent to build towards as a nation and as coalitions within hospitals and that we measure requirements that we put in place in how well we're actually able to achieve optimal outcomes, so thanks very much.

May Nacion: OK, thank you. Glen Mays?

Glen Mays: Yes, greetings. Glen Mays, I'm a Professor of Health Policy and Management at the University of Kentucky. And I lead a couple of research centers here that focused both on medical care, delivery and financing system as well as we public health system and how they best – how they interface with medical and social systems, both on a routine care situation as well as in emergencies.

I also help to lead the National Health Security Preparedness Index, which from a measurement standpoint is very relevant to work today.

I would say kind of – another major challenge that relates to some of the other points already made about achieving readiness, is really the ability of the organizations to adopt in productive way. I mean, there are shop either to on the demand side in terms of patient demanding care or shop on the supply side in terms of being able to deliver care.

And if that adaptation respond, we know often hinges critically on the relationship that exist with other actors in the system, at, you know, local state and regional level. Understanding that those kind of – that's been helpful stuff (inaudible).

May Nacion: I'm sorry. I think someone just maybe dialed in. Please make sure that your computers are muted if you're on the phone, otherwise we will get that echo.

Perfect. Sorry, do you want to continue? It was difficult to hear the endpoint of that.

Glen Mays: Oh sure. Yes, I was just saying, I think in terms of drivers what helps organization be successful with adaptation in the context of emergency (disaster), that has to do with their position in larger systems of care. There are kind of network. They're positioned in that network of other organization that are operating horizontally at local level and also vertically at state and regional level.

So those elements kind of the network dynamics and the ability to communicate, exchange information and to coordinate being critical as part of that adaptation process.

May Nacion: OK, thank you. How about James Paturas?

James Paturas: Good afternoon. This is Jim Paturas. I'm the Director of the Center for Emergency Preparedness and Disaster Response at Yale New Haven Health. I've been in this business like many people on this phone for many years and my entire career has been spent in hospital. I started in emergency

department, when into emergency medical services and wound up in emergency management. So, here we are.

I'm going to try to tackle and be very similar to many of the others. Number two, which is what is the meaning – what does it mean for organizations to be ready? And many of these points have already been made, but just to highlight them again.

For us, for me, it's really about first understanding what our vulnerabilities are. At the same time trying to grapple with our capabilities and capacities, and ultimately like we heard really getting to the level of how we define resiliency, because we'll always be there to respond to disasters. But it will really be dependent on how resilient we are to get through that as well as what we have to do.

We also need to understand under that same guides that it's going to take partnerships and, you know, having work in hospitals for a very long time. We know at times sometimes they think they have to do it alone. And, you know, that's probably not going to work. And so, partnerships are key.

And I think if the use even recent examples of either internal partnership or external partnerships, you know, those hospitals that are part of health systems are probably in a little better place in terms of the ability to be resilient. And for those that aren't, that's why we need to do this, set the standards, set the metrics and move to more resiliency. Thanks.

May Nacion: So thank you. Marcie Roth?

Marcie Roth: Hi, I'm Marcie Roth. And, first, I'm going to introduce June Kailes. Sorry, I couldn't do that sooner. I wasn't able to connect. But as June has asked me to introduce her, she's on a plane. June Isaacson Kailes, Disability Policy Consulting practice. And as a pioneer leader, an innovator in the world of healthcare emergency management and hospitality. For decades of research, training, work planning, advocacy, writing and policy development, focused on replacing the ambiguous disability etiquette sensitivity and awareness with maximum impact to critical, actionable, disability practice confidence, capabilities and measurable skill sets.

June develops practical tools and plans that close service gaps, prevents civil rights violations and emphasizing incorporate into operating procedures, the why, who, what, when, where and how detailed.

She is answering the question, what does it mean to patients for their local healthcare providers to be ready for disasters. Her answer is, in the best of world for starters, it could mean that providers have helped them to put in place a realistic emergency plan including options for building support teams of people who will be able to assist them when needed and emergency. And how to maintain supplies of life-sustaining medications, power devices, and where to see infusion therapy if their usual site is not operational, and I will then go on to introduce myself.

I am the Chief Executive Officer of the Partnership for Inclusive Disaster Strategies. The partnership represents the 61 million Americans with disabilities and 1.5 billion people with disabilities globally. Here in the US that's one in four adults. The Partnership for Inclusive Disaster Strategies has a footprint in every Congressional district across the country. And our focus is on emergency preparedness and disaster response, inclusive of people with disability before, during and after disasters.

The biggest challenge to achieving readiness for disasters in our organization is really much more of a challenge in convincing everyone else that the health maintenance need of people with disabilities, need to be met outside of the acute care setting and providing the support and technical assistant to achieve that.

I spent eight years as the Director of the FEMA Office of Disability Integration and Coordination Director. And over the 400 plus disaster deployments that I've been involved in, we have continually missed the opportunity to give people what it is they need to maintain their health, their safety and their independent and prevent unnecessary overuse of acute care.

So, our biggest challenge is convincing everybody else that health maintenance is worth the investment and that the civil rights people with

disabilities are not just a legal obligation but also good for whole community resiliency. Thank you.

May Nacion: OK, thank you so much. Lucy Savitz?

Lucy Savitz: Good afternoon everyone. I'm Lucy Savitz. It's nice to be on the panel with others that I've worked with in the pass. And I am the Vice President for Health Research. I'm the Director for Center for Health Research in Kaiser Permanente's Northwest Region. I'm also Director of Center in Hawaii. I'm a Professor in the new Kaiser School of Medicine, as well as an Affiliate Professor in the OHSU-PSU School of Public Health.

And the work that I have done in the pass has really as health services researcher, taking a medical geography approach to creating an Atlas for the United States of all the various emergency response, regions. And locations with hospitals, health departments and nursing homes and road networks, and actually that work was deployed and funded by AHRQ and Dr. Sally Phillips, who is a National Leader and Preparedness with my project officer.

So we work to bring that information forward and work out of the secretary's Incident Command Center in Washington for 16 weeks, because we were the only at that time that had merged all of that data, to allow the federal coordinated effort across various agencies and with the local community to respond to Hurricane Katrina.

And I would say, you know, I agree with everything that's been said in terms of the systems thinking and the particular need of patients and their expectations of high quality service delivery. But I think one of the pieces that I'd like to put on the table for us to think about is that, you know, people assumed that the disaster is sort of the short-term event. And as organizations and communities look to prepare, those are very wrong pulse disaster period that part of recovery that's really important to think about.

And we saw that after Hurricane Katrina. I worked in Biloxi, Mississippi for two years after the storm helping to rebuild primary care, you know, given displacements and, you know, relocations of providers and closed facilities, et cetera. Thank you.

May Nacion: OK, thank you so much. And Margaret Weston?

Margaret Weston: Good afternoon, everyone. My name is Margaret Weston. I'm a Healthcare Quality Solutions' Director with Johnson & Johnson Health System. And I have also spent quite a few years serving at the VA as the Chief Quality Officer, which provided me with experience in readiness preparation and emergency management at the federal state and the local level.

My current role, I work with health systems healthcare and employee as well as health collaborative in a variety of projects focusing on quality improvement, efficiency and outcomes as these organizations move into value-based model.

I tackled the question, what does it mean for organizations to be ready for disasters – for a disaster. And I think that what I see most is effective as approaching disasters from a system and community operations level with the process development methodology so that goals and responsibilities are very clear, resources can be optimized, lines of communications are pre-planned and that as much risk as possible can be mitigated.

May Nacion: Great, thank you so much. Thank for all the committee members who are here today and who've responded to our one or two questions there.

I'll turn it over now Poonam to provide an overview of NQF.

Poonam Bal: Thank you, May. And I just want to remind everyone, I made a comment during the instructions. But just as a reminder, all seats on this committee are subject matter expert individual seats.

And while you're definitely going to bringing forward you're knowledge and experience on the organizations that you take part in, you know, we just want when you introduce yourself and when we continue our discussions that you not represent an organization or an entity that you may be part of. But really speaks from your own experience and that maybe that in my experience when I was at this organization we did this, that's fine.

But we just want to make sure that, you know, we're not making appear that organization as a whole are representing on the committee. So I just want to make sure that we make that clear and just share it with you, and, you know, obviously, it's our job to work with you to make sure that the little caveats that NQF are achieved.

So with that, I will do an overview of the National Quality Forum.

So we're in a pretty unique role, very niche. We were established in 1999 at the nonprofit, nonpartisan membership-based organization that brings together public and private sector stakeholders to reach consensus on healthcare performance measurement. In short, the goal is to make healthcare in the US better, safer and more affordable.

This has really led to our mission, which is to lead national collaboration to improve health and healthcare quality through measurement. We do that by being an essential forum, by bringing together stakeholder groups from all rounds of the health system, and to really understand what it care and who needs to be involve and doctors that we need to consider, not from just one point of view but for many, for being a gold standard for quality measurement.

So we do have our CDP work or consensus development work where we go through and actually say these are the measures we recommend are moved forward and use and so on.

And then just being a leader in quality. This project is more in that ground where we try to set standards and move measurement forward in a positive way.

So our mission is kind of really stated there. We do this by, you know, building consensus, endorse national consensus standards in education and outreach. I mean, you know, by doing that we're a neutral convener, you know, you really want to be bias free that's why I gave that introduction about making sure that you are an individual and not an organization.

And so with that, we do have work in multiple measurement areas. I've already mentioned that the development process or performance measure endorsement is commonly known. We currently have 600 plus NQF-endorsed measures across multiple clinical and crosscutting areas. We have 15 standing committee that review these measures and give recommendations.

We also have the Measure Application Partnership or MAP. That is more of an advisory role to HHS on selecting measures for the 20 plus federal programs, Medicaid and health exchanges. So it's much more about selection and providing recommendation by moving forward.

We also have the National Quality Partnerships. Their role is to convey stakeholders around critical health and healthcare topic and then spear action on patient safety, early elective deliverables and other issue.

The last section is measurement science and that's where really this project is part of our work. We convey private and public sector leaders to reach consensus on a complex issues in healthcare performance measurement and some of the projects we've done in the past or attribution, alignment, and SDS.

And with that, I'll give it back to May to go over overview of our readiness project.

May Nacion: OK. Thanks, Poonam. Going on to the next one. So as you know we've definitely heard from our Jack Hermann from ASPR and their priority of healthcare readiness. And this project really came about because despite the importance of healthcare systems during these emergencies, there is really this lack of quality metrics to assess how ready systems and community are during these events.

So the objectives of this project are to convene a multi-stakeholder committee, develop a measurement framework informed by an environmental scan findings and committee input, define the concept of readiness with the help of the committee. And then, finally, develop a written report summarizing the results of the environmental scan as well as the measurement framework and the committee discussion regarding readiness.

Next slide. OK.

So this is just an overview of our timeline. Our next meeting will be on October 11th, and our last meeting will be on May 9th, 2019. And you will be receiving outlook invites for these meeting dates. Next slide.

As far as your role as committee members, you are here as experts to help NQF achieve the project objectives. You are expected to review the meeting materials and participate in all meeting. And finally, as our experts, you will be providing us guidance and input on the scan, identifying measures and measure concept, helping identify any measurement gaps, helping us to develop the framework, and certainly finalizing the report. Next slide.

The role of project staff. So as a project staff, we are responsible for ensuring the project objectives, to ensure the objectives are met by organizing all the meetings and calls, ensuring there's open communication between committee, the committee members and NQF, responding to questions from committee members, the public, or NQF members, drafting and editing the report, and finally, publishing the final report.

Where there any questions during these specific slides on our objectives, on your responsibilities as committee members? If not, I'll turn it over to Poonam to discuss measurement framework.

Poonam Bal: Thank you. So what is a measurement framework? If you've been involved in NQF before but not one of our measurement science project, you may not be familiar with what this really means. This is just a term that we use for a conceptual model for organizing ideas about what is important to measure in a topic area.

So generally, measurement frameworks are made of domains of measurements, sub-domains in measurement, and then measure concepts. Essentially, the measurement framework provide a structure for organizing currently available measures, identifying measure gaps and prioritizing measures for future development.

All in all, it's essentially we are going to take information from our environmental scan, really try to understand what are the big issues and challenges currently in the field. And then see how can we measure or how well we're doing to overcome those challenges and to be ready for any disaster, so that's essentially what a measurement framework goal is.

And so what goes into measure framework? So our process is, step one, is really bringing together a multi-stakeholder group, thus, this group that we've gathered. Then we'll do the environmental scan and in a little bit we'll talk a little bit of our initial findings and where we are with that.

But essentially, this is involved in literature review and in measure search. We are not doing key informant interviews for this project. So essentially, you know, we've scan literature to see what's out there right now on readiness and to see if there are any measures or measure proxies that we could use to see what else is already out there.

Once we do that, we will (concise) the findings and share themes and concepts and ideas with you to get your feedback on. If we captured what we needed to, we'll use that as our basis for creating a conceptual framework and then go from there. But again, that will go to the committee for your review. We'll update the framework as we go through.

This may have to go through several iterations depending on if we, you know, how on point we are if we need to move forward and keep thinking through this. And then after couple of commenting period, we'll go through and actually create the final framework which will be the deliverable.

So what are the considerations for this framework? Truly, what is the desired outcome for the individual? We should be creating measures or measure concepts that really get to the outcome that we're hoping to achieve. Is there an accountability entity that has the ability to influence what should be measured? Is there availability among providers and opportunity for improvement? What is feasible to measure in the short, medium, and long-term? So these are all the things that we should really consider when developing the framework.

Elements of a framework. So, as I already mentioned, there is the domain, subdomain and measure concept. Part of that – so domain is a grouping of high-level ideas that further describes the measurement framework. Subdomain is a smaller category or grouping within the domain. And the measure concept is a description of a potential assessment tool that includes planned target and population.

The hope is by developing this measure concept through the measurement framework, there will be a performance measure that is created outside of our work that will take what we created and make it into an actual measure.

So to give you a little bit more of an example of what you mean with this, we've used the ED Transition of Care Project which occurred a couple of years ago. Their domains were provider information exchange, patient family, and caregiver information exchange, engagement of the broader community, and achievement of outcomes.

These again are examples and the outcomes – I'm sorry. Domains really differ depending on the projects and what the standing committee feels is the right areas to focus on. So don't feel that they have to be similar to this, but this is just an idea for you to get a better understanding of what we're going with here.

And under the domains are subdomains. So for provider information exchange, two subdomains where key information elements and priorities of transmission, and then care coordination and feedback, and then we may measure concepts underneath that as well.

So going off with the original idea, so if we go engagement of the broader community which are their domain, the definition of that domain was it represents the extent to which the broader community's organizations, services, and information technology infrastructures are available and engaged to support a quality transition of care into and out of the ED.

A subdomain underneath that was connection and alignment. And that was defined as this subdomain addresses the identification, availability, and

engagement of appropriate clinical and nonclinical community services that support a transition of care.

Underneath that subdomain a measure concept that was created was assessing high-risk patients who are at risk for a transition failure due to unmet social needs. Unfortunately, there was not a real performance measure that we could place here as an example of what could come out of that concept but the idea is that once the framework is created someone would take it and develop performance measure.

And so before we jump into the actual environmental scan and some of our findings, I want to pause to see if there were any questions about the things that I mentioned.

Scott Aronson: Yes, this is Scott Aronson. I just had a quick question. You were eliminating the key informant interviews, was there any specific reason on that piece or is that an optional element to include just because in disasters, it's so beneficial to continuously interview people who have been through running their health care systems and other elements there?

Poonam Bal: It was not an optional thing, so each framework does differ. That was a standard diagram of what could occur for this project. There was key informant interviews weren't stated in the funding process. So we aren't moving forward with that. But obviously, as we move forward, if we find that we need to get more information, we definitely can.

Scott Aronson: OK. Thank you.

Poonam Bal: Any other questions? OK. With that, I'll give it to our two senior directors.

Kyle Cobb: OK. Hi, everyone. This is Kyle Cobb and I'm going to go through the environmental scan with Debjani. And I just, you know, also as a follow-up to Poonam's response to Scott about key informant interviews. I think, you know, there are certainly different approaches to when we collect information to support the development of frameworks. And, you know, if we feel through the environmental scan process and early meetings with the committee that there really are – is a need for specific key informant

interviews to inform the work of this project, we can certainly consider that. I think it's just – it was not something that we had anticipated.

In large part, it was the subject area. And I think, you know, in large part also, because of the committee members and the types of community members, we have many of which are we believe to be really essentially, you know, better than key informant interviews.

So with that, we are really excited to have all of you on our committee and welcome and thank you so much for participating in the project. I will move through these slides pretty quickly. I think you're all petty much familiar with sort of a general approach to what environmental scans are. We'll go to the next slide, Poonam.

But just to sort of show you what a typical approach for NQF frameworks are, it's important to note that, you know, the goal of the scan is not only to identify existing measures or measure concepts, and relevant frameworks, but we're also looking for instruments or tools that may assess elements of readiness that could be considered as metrics.

So it's a bit of a balance here where we do the scan. And as I'm sure everybody is aware, there's a lot out there but not specific to what we are doing, so a lot of general information, but nothing specific, or not nothing but few things.

Next slide.

So I think the main point on this slide is that we are, you know, environmental scans are foundational to developing these frameworks. We are not developing measures however, but we do – we will be identify existing measures or concepts out there that may be put forth in our framework but in general we're not going to spend our time as the committee sitting around and thinking about how to develop concepts, which is a slightly different intellectual pursuit than what we're doing, so but good to we're clarifying.

Let's go to the next slide and look at the definitions. I think, you know, we all – we have found that getting – establishing definitions early on is important

and I'm sure you all agree and even recognizing that some of them may change as we learn and research more on this project.

For measures and measure concepts, this is the NQF definition to differentiate between measure and measure concepts. And, you know, simply put measures are a bit more developed – a bit more big than a measure concept. Next slide.

Here are our working definitions for the project. We do – for preparedness and readiness, I don't – I won't assume that everybody is actually looking at the slide. So we have two definitions, one for preparedness and one for readiness. I will, you know, we do expect the committee to have comments and reactions and feedback to these definitions and we hope to discuss this with you even later on the call today and, you know, of course during the project. Next slide.

A couple of more definitions for response, recovery and all hazards. And then I will – I think the next slide, I will hand it over to Debjani.

Debjani Mukherjee: Thanks, Cobb. So this Debjani again, and what I'm going to do is talk to through some of the research questions we looked at to perform our environmental scan and then (help you see) about the (search) terms we used.

So for the research questions, we wanted to start off by focusing on measures and measurement as well as frameworks. And as you may have guess by now when we started looking at the current landscape of hospital- and community-based performance measures that specifically focus on readiness, and look at readiness and sort of try to assess the level of readiness. There isn't that much out there.

I mean I will note that what is available is focused on preparedness but when you were specifically focusing on readiness, which is what we are doing for this project, there isn't other left out there.

And when do we need – when looking at these search questions as well as performing the searches, we sort of look at the broad community. So health

system including like the hospital, but all other providers in the community and sort of the continuum of care.

And then, the place where we did find most of our information was when we started looking at commonly use framework that address emergency readiness and a lot of these came out after 9/11 and Katrina and Irene and Sandy and all of that. So, specifically, we're looking at frameworks, and these frameworks are again related to readiness. And the ones that we're focusing on are the ones developed by the Joint Commission, CMS, CDC, and FEMA. Next slide please.

And then, this slide focuses on some of the other questions that we also looked at. And just to give you a quick update, we probably found also the information for the first two questions and these are the ones that we, you know, were good to know, nice to get information on. But, you know, it wasn't imperative.

So we looked at elements of readiness and looking at like all hazards. We started looking at perspective for framing the concept of readiness and measuring as well as priority gap and healthcare systems readiness and measurement. And this is a quick summary of these questions. These are the questions we use to do our environmental scan but we will also circle back to these questions with you all and sort of rely on your expertise as we progress in this project. Next slide, please.

And what this slide does is it list some of the search terms to be used. So when we did our environmental scan, we definitely used MeSH searches but we used PubMed. We also look at the gray literature, Google Scholar and we focus on measure, survey, scale framework. And within this context of readiness and readiness, we sort of broke down into capacity building, disaster planning, emergencies, all hazards, emergency responders, healthcare services needs and demands. So that's how we went about sort of doing our search we use these terms, those questions that I just went over and then we conducted our searches.

And with that, I will open it up for some committee discussion for your initial thoughts.

Cullen Case: Hi. This is Cullen from RITN. So my thought is you're saying that the difference between readiness and preparedness and I had to go open the slides to look at the definition again. And it seems to me that the readiness if that's where we're going try and measure results from the preparedness and it can only be measured in hindsight if they were ready.

So if a disaster happens and then they responded well, then they were ready. But the measurement then would likely have to either be hindsight or have to be based on the preparedness that results in them being ready. That's just my two cents. Thank you.

Steven Krug: Hey, this Steven Krug. Same point. I mean, actually preparedness might be more of a structural and/or process. It's going to be tough to measure readiness because there aren't very great ways of measuring that in actual events, although there are some terrific simulation tools out there that we should look at as a way to kick the tires on the system in the absence of a response that really assesses a healthcare system's ability to respond to a disaster.

Kyle Cobb: Thanks, Steven. This is Kyle, and, you know, we actually have discussed that sort of play between structure process outcomes quite a bit, when thinking about preparedness and readiness and certainly agree that readiness is potentially an outcome of preparedness.

Matthew Knott: Perfect. And this is Matthew Knott. I mean, those are fantastic points that, you know, good way to measure readiness without – with the absence of an actual incident is training and exercises, and specifically those exercises having metrics in place that develops a good, useful tool to test that preparedness that those institutions are working on.

Kyle Cobb: Yes. Thanks for that. Any other initial sort of thoughts or reactions to definitions or anything that we've shared about the environment scan?

Well, thanks Cullen, Steven and Matthew, those are really helpful thoughts you shared with us. And we'll be back – I don't have the exact date because I don't have a timeline in front of me. But in the early October, we will have a meeting and have a lot more information for you then.

And, you know, I would certainly just – if the members of the committee have things that they think would be – we would benefit from reviewing sooner or rather than later whether it'd be the simulation tools, that you mention, Steve, or other papers or anything, do send them our way. We will get to all of the communication aspects of those projects next. But we absolutely encourage folks to share materials with us now. Thanks so much.

May, I think you may be on mute.

May Nacion: Thank you, I was. OK. So I'll just provide a really quickly SharePoint overview. We can get to the next slide.

So throughout the list of the project, the NQF team will be sharing documents with the committee through the respective SharePoint page. Today, all committee members either today or sometime this week, you are scheduled to receive your credentials to access to SharePoint site. Again, if you don't receive your credentials by end of this week, definitely reach out to the project team and we'll work to gain you access to that SharePoint site.

So once you see your SharePoint access instructions, we do encourage you to tour the site, you'll notice that today's meeting materials have been posted as well as the calendar of meeting.

Next slide.

So, this is a screen shot that reflects an early version of the readiness homepage but it has been updated with additional documents. This is what it looks like. So in the left hand side, kind of the menus, the main page shows you all of the documents and they will be on the main page, all right?

Next slide.

So do keep in mind that SharePoint does like to hide documents. So if you're having trouble locating some documents, it maybe because the meeting or folder you're trying to access hasn't been expanded to reveal its content. So, you can expand or hide the content by clicking on the plus and minus signs, circled here on the screen for you. So that's how you collapse and expand documents or folders, right.

Does anyone have any questions regarding SharePoint overview or accessing this? You probably won't have any now but certainly once you do have your credentials, please make sure that you can log in, that you have an idea of where things are. And if you do have questions, please feel free to e-mail us. All right?

And then I think we will move on to public comments.

(Kathy), if you could open the line for public comments.

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

Poonam Bal: May, while we're waiting for public comments, why don't we just go ahead and do next steps so that way people have time to line up if they have questions.

May Nacion: OK, sounds good to me. All right. So for next steps, for the committee, again, as Kyle said, if you do have any other suggestions for us regarding more documents or exercises that we wish look into for our environmental scan, please feel free to send us that information. Our e-mail will be coming up.

But as far as meeting dates go, our next meeting will be on October 11th at 12:00 PM Eastern Time. And then, during that meeting, we will be discussing more in-depth regarding the environmental scan and our findings. Next slide.

So this is our project e-mail. Please e-mail us at readiness@qualityforum.org. Again, with any questions, comments, recommendations for additional documents, exercises to look for, our phone number is there. This is our

project web page, so this is a public project web page. And then there is also a link for the SharePoint page and only committee members will have access to that SharePoint page, OK?

Let's see if there are any more public comments.

Operator: There are no public comments at this time.

May Nacion: OK. Did anyone else have any questions that you'd like to ask us before we end the meeting?

(Pat Riley): I just want to say hi, this is (Pat Riley). I'm a proposed committee member and have been listening in and look forward to working with you all.

May Nacion: OK. Thanks, (Pat).

All right, if there's nothing else, I think we will close this meeting. NQF staff, did you have anything else to say?

Kyle Cobb: Nothing other than thanks so much everybody for calling in today and we really look forward to the work we'll do with you over the next nine months or so.

Female: Yes, thanks.

Female: Thank you.

Male: Thank you.

Female: Thank you.

Male: Thank you very much.

Male: Thank you.

END