NATIONAL QUALITY FORUM

Moderator: Sheila Crawford
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11:29 am CT

(Tina): Okay as she said...

((Crosstalk))

Woman: Okay.

(Tina): ...we are now being recorded. We are using a new conferencing system that we're still working through to make sure that we're NQF staff are on board with so please bear with us as we try to make this as efficient as possible. To the committee members on the line there was an email sent out about some of the tricks and trades the new conference system how to mute yourself, unmute yourself and raise your hand and all those things. So please incorporate those and have that email ready to go to help us make this efficient.

So with that said I think that if you have your computer on that perhaps it will also cause some - not computer on, but your computer listening into the meeting it might cause some friction so if you're hearing some overlap that might be why. So with that I'm going to give it to (Nadia) to do the roll call.

(Nadia): Thank you (Tina) and I do apologize if I mispronounce any of your names. So let's begin (Paul Bettinger)?

(Paul Bettinger): Yes here.

(Nadia): Thank you. (Margaret Wilson)?

(Margaret Wilson): Yes I'm here.

(Nadia): (Scott Aronson)?

(Scott Aronson): Yes I'm here.

(Nadia): (Sue Ann Bell)?

(Sue Ann Bell): Here.

(Nadia): Thank you. (Emily Charter)?

(Emily Charter): Here. I'm going to have to drop off for a little bit part way through but I'll rejoin.

(Nadia): Okay thank you for letting us know (Emily). (Colin Case)?

(Colin Case): Here.

(Nadia): Thank you. (Barbara Siderella)?

(Barbara Siderella): Here.

(Nadia): (Caitlin Derve)?

(Caitlin Derve): Here.

(Nadia): (Alexander Garza)?

(Alexander Garza): Here.

(Nadia): (Jennifer Greene)?

(Jennifer Greene): Here. And I'm sorry for missing December. I was in - unexpectedly in the hospital during that meeting.

(Nadia): Sorry, glad to have you back with us (Jennifer). Thank you. (Angela Hewitt)?

(Angela Hewitt): Here.

(Nadia): (Bigela) (unintelligible).

(Bigela): Hi. This is (Bigela).

(Nadia): (Mark Jarrett)?

(Mark Jarrett): I'm here.

(Nadia): (June Kales)?

(June Kales): I'm here.

(Nadia): (Andy Knot)?

(Andy Knot): I'm here.

(Nadia): (Stacy Kokoram)?

(Stacy Kokoram): Hello. I'm here.

(Nadia): (Steven Cruise)?

(Steven Cruise): I'm here.

(Nadia): (Nicolette Lousan)?

(Nicolette Lousan): Here.

(Nadia): (David Marcosi)?

(David Marcosi): (Marcosi)'s on.

(Nadia): (Glen Maine)?

(Glen Maine): Yes I'm here.

(Nadia): (James Peturas)?

(James Peturas): Here.

(Nadia): (Patrick Riley)?

(Patrick Riley): Here.

(Nadia): (Marcie Ross)? (Lucy Savis)?

(Lucy Savis): Here.

(Nadia): (Jay Taylor).

(Jay Taylor): I'm here but I'll be traveling here today heading for Philadelphia going to catch a train here in a little bit so I'll do my best to stay connected for the whole time.

(Nadia): All right thank you (Jay). And I will turn it back to (Tina) (unintelligible) rest of the thing.

(Tina): Okay thank you. So if you go for those of you are following along we're going to go to Slide 6 here which is basically an intro back to what we've already been kind of telling you about the goal of this meeting is and what the goal of this project is. Before I jump into the details of what we're going to be talking about today and how we hope to proceed I did want to let you know some options to hopefully make this a productive conversation. So right now (Nadia) is going to go ahead and mute everyone's lines. Once she does – I'm going to let her do that because it does make a noise so. Sorry, give us one second. Still learning the system as I mentioned.

So while she's getting that ready I'll just go over some of these other things. But we're going to mute your line. All right now I'm going to do it.

Operator: The conference has been muted.

(Tina): All right so we have muted everyone's line. You are able to unmute your own line by that instruction that we sent to you in your email. You can also raise your hand if you're unable to unmute yourself for some reason. But we're also asking you to make this a productive conversation that people if you want to talk on a topic instead of just jumping in and kind of talking about it we ask that you raise your hand and then that way the co-chairs can call on you are actually we'll call on you to let you know it's your turn to speak and then the co-chairs can guide the discussion that way.

We also ask if you just want to agree with the person that's speaking or you have a point to make that you don't think really needs to be announced on the phone maybe you agree or you disagree or you just want to add some more emphasis on something that's already been said you can also use the chat box to send that to staff.

If it's something that you want to add, we will speak out loud for you and present it. I think this would be a good way for us to keep it going especially if perhaps we're talking about one topic and then people start going off on another and you want to go back to that old topic, you can always chat us and be light for that topic we were just talking about this is my note and then we can try to bring it back so we can have a thorough discussion about that.

So knowing that, you know, we have conference calls instead of an in-person meeting we are trying to do this three day system where for the next three days we'll be talking about essentially the same thing but about different topic areas. And we're hoping the fact that they are back to back and we can have a consistent conversation and where people won't be like oh what did we talk about last time and so on. So this is kind of the topics that we're using to make this a more enriching conversation. And so with that actually (Nadia) do you

mind unmuting everybody? I just want to see if there's any questions about the system?

Operator: The conference has been unmuted.

(Tina): So were there any questions about how to use the conferencing system, any questions about, you know, what we're hoping to talk about today? I know I haven't gotten in detail about that whole topic areas but just a general gist? Okay all right, we're going to mute everyone again.

Operator: The conference has been muted.

(Tina): Okay. So with that I'll start with Slide 6. So just as a quick reminder - oh and also just to let everyone know, if you hear that little beep that just means that someone has either joined or left the call. I know I can get a little distracting but just wanted to warn everyone.

All right so with that a quick reminder of kind of our objective is mainly to create a measurement framework that's informed by the environmental scan. In order to do that we will do a written report of the measurement framework. And that's what we're currently developing. We started a little bit with the discussions that we've already had on these calls based on the environmental scan it will be further developing and with your help over the next three days. So what is a measurement framework? Again this is something we've gone over before but essentially the conceptual model for organizing ideas about what is important to measure for a topic area and how measurements should take place.

So underneath that we'll have domain, subdomain measure concepts and measure. It's a tiering system so the domain is that category of what we want

to focus on. Subdomains under that main domain what are some subcategories that we want to focus on and then measure concepts and measures are the real meat of the topic where this is the area we want to focus and the things that we think there should be measurement in or there's measures that already exist that we think should be incorporated in for the readiness work.

So next slide please. So with that we did want to bring back the two definitions we've talked about. We know we've had a lot of discussion about this and we just want to make sure that everybody was on the same page. When we talk about a healthcare system we mean all entities that directly deliver healthcare services to promote continuing and timely care across multiple providers, health systems and communities. We wanted to make sure that was a very clear definition. It hasn't really changed since we showed it to you, but we have changed some of focus so you can really understand it so, and hopefully now agree to it. So we're counting any entities that provides deliberate healthcare services but it has to also be across multiple providers.

A healthcare system generally won't be considered just like a health system or one entity but it is possible that based on where you are based maybe there is only one healthcare entity that would be providing all care. And so it's really up to them to make sure that they're, you know, providing the best readiness care as possible. So it's - that's a rare situation but it's trying to be all-encompassing for all the different areas that the United States deals with and kind of the situations they have for health care system.

Then for readiness again it's just the (unintelligible) hospitals, healthcare systems and communities to rapidly identify, evaluate and react to a wide spectrum emergency condition related to a disaster or a public health emergency. We have gone even further with that to say that its readiness is a combination of the four phases, so mitigation, preparedness, response and

recovery. We're saying readiness is that perfect spot in the middle of all four of those identifying what needs to get done.

So we've also provided some definitions of mitigation preparedness, response and recovery for you. They're listed here. I won't go into details of reading all of them but essentially a mitigation is something that we consider is a set of measures to reduce and neutralize impact of natural disasters by reducing social, functional or physical variability and that is something that can be done before or after a disaster. Preparedness is organization education training of the population at all relevant institutions to facilitate effective control, early warning in - rescue relief and assist in operations in the event of a disaster or emergency. We usually consider preparedness to be before a disaster.

Response to some of decisions and actions taken during or after a disaster including immediate relief, rehab and preconception. Again this is considered something usually after the disaster - I'm sorry, occurs during the disaster. And then recovery is something that's considered after the disaster which is a set of, (unintelligible) set of procedures that are taken to return to a normal or safe situation post disaster and takes place post emergency. So I'm sure you all are very familiar with those definitions but I just wanted to kind of go through what - how we're defining them.

And so now for the health care system readiness the scope. And I think this is something that we have been dealing with in the previous calls so hopefully that more detailed description of healthcare system and what we mean by that has helped people kind of narrow down what they're thinking. But really our focus is quality measurement of healthcare delivery prior to, during and after disasters in public health emergencies. So we do need to be able to account for all different phases. That's the mitigation, preparedness recovery and response portion need and then we also need to think about for all hazards. So that does

make our job a little difficult when we have so many different elements that we need to take into consideration.

And so keeping that in mind that's why the guiding principles were created. It's based on the feedback that we received in the homework assignment, the homework assignment that we saw. We did - it seemed clear that people didn't really understand the point of the guiding principles or how they'd be functioning within the overall framework. So we did want to provide some clarification about that.

These are - guiding principles are essentially factors that you should be considering when you look at this framework. What are some overarching considerations when someone looks at the framework and they're trying to determine which measure they should be using and which measures are appropriate for their health care system. You know, as we mentioned it's a all hazard and a all, you know, size location all, you know, population kind of measure. So we'll have to keep measures that can be used in a variety of entities in a variety of types of healthcare systems.

So what - keeping that in mind we create the guiding principles as something to help us keep that in - to guide us as we look at this and to help anyone who's using this framework to see okay, well I should be keeping this into consideration or I should be using this as a way to decide if it's appropriate for me or not. So with that in mind we did make some slight changes to the guiding principles. So originally in the slides that we sent to you we had said that it was person focused readiness. We did realize it got a little confusing because then it brings in kind of the community aspect that we're not really focusing on. And so we did change that to patient focused readiness.

And then at the bottom there was originally retroactive measurement. And again we understood that that could be confusing as saying that oh we should, you know, someone could be penalized for something they did in the past in the future. So we just meant that that meant - means that sometimes the truest measurement of readiness would be after the event happens and could not always be done in preparation for it.

And I also want to add there's not a guiding principle on here but we will be adding it which is the at-risk population. We had this in our mind realize that it's not - it needs more importance and should be a separate guiding principle versus just being incorporated into the overall framework.

So before I jump into the framework and really the core of our work together I know went through a lot of things very quickly, mostly just summaries of things that we've talked about before, I wanted to see if anyone had any questions or concerns before we get into the meat of our work. And if (Nadia) you could unmute the lines please.

Operator: The conference has been un-muted.

(Tina): Okay did anybody have any questions about the things that I just went over?

(Scott Aronson): And this is (Scott Aronson). I just noticed that so capacity and capability focused readiness was also removed that was Bullet Number 3 previously and that was about maximizing institutional capacity and delivery of care.

(Tina): Okay that was just an error on our part. That is still a guiding principle.

(Scott Aronson): Got it, okay.

(Tina): Thank you for noting that.

Woman: Hi. This is (unintelligible).

((Crosstalk))

Woman: A quick question about the definitions. So under readiness I'm just wondering the rationale for separating hospitals from healthcare systems because they're not separate. I mean healthcare systems are larger, include many more entities but hospitals are certainly a key part of the healthcare system but having them called out separately and readiness makes them seem like they're not a part of the healthcare system.

(Tina): That's a great point. We'll delete the possible point part.

Woman: Right.

(Tina): Thank you for catching that. I believe one other person had a note to make.

(June Kales): (June Kales). I'm just going back to the patient focused versus the individual focus. We're talking that about systems. Now people don't always identify as a patient outside of some of these facilities. So and we're talking about a broad scope of touching people. So I just think patient may still be too limited in terms of how people interact with all of the systems and not just a, for example hospital system.

(Tina): Okay I think that's fair. We can rethink that and see if there's some other terminology that we can use that would be more appropriate. And I do want to let everyone know that for - I don't know about our late January meeting but we are hoping to get to you a pretty detailed framework, you know, before we

go out for commenting. And so with that we will add in more details around these guiding principles and exactly what we mean. But I think that's a good point to make it we can try to see how we can make that more clear. Thank you.

(June Kales): Thank you. And I had one more. Can you go back to the guiding principles slide for a moment?

(Tina): Yes one second. All right there you go. You should see it up now.

(June Kales): Oh okay. So you did remove - okay it is clear now. You made it post-event before you had the retroactive so that is clearer. Thank you.

(Tina): No worries.

(Marcie Ross): Hi this is…

(Tina): Go ahead.

(Marcie Ross): …this is (Marcie Ross). So would it make sense to have a guiding principle that speaks to the legal and civil rights obligations regulatory something? I don't see anything in here that speaks to that?

(Tina): I think we need to think about that more. I think that might be a little bit more community-based than what we're hoping to focus on but we can keep it on our radar and see if that fits in with this one.

(Marcie Ross): This is (Marcie) I appreciate that. I think the facility-based compliance obligations are so huge that I would not - I would hope we're not just be looking at this outside of that focus, happy to talk about it more.

(Tina): Okay thank you.

(Bigela): And this is (Bigela). And also when we're thinking about readiness and especially when we're thinking about measures and things we're looking from a quality perspective and which is why we're not necessarily looking regulatory as sort of a (JACO) requirement but it is definitely something we can bring back to the team and think about.

(Jesse): And this is (Jesse) here. I agree. Actually I think a lot of the regulatory stuff does appear on the next slide when we actually talked through the measurement directly.

(Colin Case): Hi this is (Colin Case) going back a couple of like three comments on the readiness definition where you said you're going to delete the healthcare systems if I understood you?

(Tina): We're going to delete hospital because it should already be incorporated in the healthcare system use language.

(Colin Case): Okay I was just going to suggest maybe it's ability of hospitals and other entities within healthcare systems but I think that's close enough with healthcare system. Thank you.

(Tina): Of course. Any other questions or comments?

(Mark Jarrett): Yes this is…

(Steve Bertuzzi): (Steve Bertuzzi).

(Tina): I'm sorry I couldn't capture both those voices. Go ahead.

(Mark Jarrett): Hi it's (Mark Jarrett), just not to beat a dead horse with this on the readiness I mean I would, you know, I agree with getting hospitals out separate than healthcare systems but I would put in, I would maybe make it generically the ability of providers because we've got to remember they're going to be physicians out in the communities who may be the first responders so to speak to see an event or be involved with events. It's not always going to be hospital-based.

(Lucy Savis): And this is (Lucy). I'd like some last comments on (unintelligible) and hospitals within health systems because not all hospitals are in health systems. So yes to (Mark) just limited to health systems.

(Mark Jarrett): Right.

(Tina): Okay.

((Crosstalk))

Man: (Unintelligible). I'm on the guiding principles side. I think we need to be rooted in the fact that all of these issues are around outcome driven issues. And to me I thought about joining this group initially the hope is to not only think about process and structure measures but to think about outcome measures. So I would think that we would also in addition have a patient focused readiness, we would have an outcome focused readiness. So those are my thoughts.

(Tina): Yes, so I think we are thinking already like overarching but not necessarily having on guiding principles (unintelligible). And once we get to the actual

measures we can definitely focus on have more outcomes and patient reported outcomes. But thank you for that. Okay any other comments? Once we're done here we will go back to the hand raising process. I think this one - I wasn't anticipating so many questions and so I left it open to that (unintelligible) go through that yet. So were there any additional comments or concerns before we move forward? Okay so now I'm going to again mute all the lines.

Operator: The conference has been muted.

(Tina): Okay so now if you go to Slide 15 we did restructure the framework diagram I guess you could say that we had created initially. We had those four big blocks and, you know, the subdomains listed and we had examples in there but it became clear that people thought that's what we were going for as the whole thing. And it also just didn't do a good job of showing the fact that all these things are not linear, they're ongoing.

So we did re-created, again this is just a visual assistance for all of us as we go through but we've re-done it where you can see that the four phases are now, you know, working together and they're all ongoing. We also created the overarching circle that talks about how throughout that things will be made, changes will happen because of regulation, accreditation and other ongoing quality improvement and feedback. So it's a big cycle of constantly ongoing and there's no okay we're done or if we go through XYZ this is how we get there. So hopefully this new diagram is a little more clear and gets across some of the points that were made during the assignment that we asked.

Next slide please. So (unintelligible) could you go back to the original diagram? Thank you, yes. So I wanted to note so the way that we're going to be running the next three meetings, so essentially we originally, you know,

had it down by the phases but it seems more appropriate that we get everything done by domain. So we - so remember the domains that we selected during our previous meetings were staff, supply, structure and system. So breaking those down and understanding what's - is incorporated into each one of those four and then understanding what measures should be incorporated.

It seemed to make sense to start with one at a time, get all the subdomains and measure concepts and measures covered and then move onto the next one. So that's the goal of these meetings is to slowly go through and finalize subdomains and finalize measures and measure concepts that fall under. I'm not going to make it appear like this is your last chance. This is the beginning, you know, this is when we're really trying to get as concise of a list as possible.

You will notice that we did send you along with the slides we also sent you a Word document or PDF document that had measure of concepts listed that we had pulled from the assignment that you had done and some suggestions from there and (unintelligible) already incorporate them. The goal is the next three days is to really finesse slows, the list that we've come up with. It's either to say this is not appropriate and should not be included or that this is missing, is like a major either subdomain or it's something that we should have a measure concept added on and be monitored. And we'll continue to finesse that list as we go on. It - don't feel like this is the only time you'll have an opportunity and then don't think like once something's in, it can never be removed. We will obviously continuously reach out to you for input to make sure that we're on the right track and really getting the information that you think is important out there.

So with that I will start with the staff section. And you'll - if you have gone through the full slide deck you'll notice that there is a section just like the staff one for all of the other domains. So the staff domain we have come up with seven subdomains under the staff domain. I do want to note that all the points that are under the subdomains are just examples. It's not supposed to be a comprehensive list. It is meant to be to give you an idea of what we think would be incorporated underneath this subdomain. And then as we jump into more the measure concepts and what we want to cover under each of the subdomains we can go into more detail about what we see covered, what's not as important, what's more important and so on.

And so with that the domains that we gathered from the assignment that you all filled out were communication, establishing testing and activating functional staffing plans and support plans for staff and volunteers, establishing training plans, staff and volunteer recruitment, registration and retention, staff safety, coordination of response across continuum of care and data and qualification of response and recovery efforts. So that's the overarching subdomain.

Again to remind you subdomains are supposed to be kind of the big category. So we're saying staff is the main category. We want to make sure that there are measures under the staff category. And then underneath that we're saying here are the biggest ticket items that we really want to have focus on. We need measure or measure concepts under each one of these subcategories and that's how we know to move forward.

So with that next slide please, so very generic slide. We do ask and hopefully you have already reviewed the measure concept document that we set out to with suggestions with different measures to consider as we move forward on this work. So with that let's unmute the lines of (Margaret) and (Paul) please.

And then while we're unmuting the co-chairs' lines I did want to just go through an example of what we're hoping to achieve today.

So for the example of the subdomain communication which is the first one listed under staff we're hoping to achieve measure concept. So it's actually it's an example of staff communication and emergency protocol within a unit, healthcare entity-wide staff communication of emergency for protocols, healthcare entity-wide staff with patient and caregiver communications and things of like healthcare entity to healthcare entity within the healthcare system communication of health coordination plans.

There are also perhaps measures that already exist that would fall under staff communications such as this measure listed here as part of the emergency operation plan, the hospital care so how it will communicate during emergencies. So that's kind of an example of what we're hoping to achieve under each one of the subdomains. Again this is an example and not all inclusive. Okay so we now have (Margaret) and (Paul)'s lines opens. Thank you.

And so were going to jump to the first discussion. There we go. So this is going to be on the actual subdomain. Again the goal is to come to consensus on the subdomains under the staff domain. We'll talk about the other domains later but let's focus on the staff ones.

And the questions we're really asking you to answer are what subdomains currently listed do not fit into the staff domain? Is there something that we selected that does not seem appropriate? Are there any subdomains missing? Did we miss something big that really needs to be covered that's not currently covered by the subdomains that we've created? And then how do those

subdomains fit into the four-phase model of preparedness, response recovery and mitigation?

So with that I'll give it to (Paul) and (Margaret). We do ask that again if you would like to speak to please raise your hand and we will go ahead and unmute you and then you can do your question but I'll give you to (Paul) and (Margaret) to start.

(Paul Bettinger): Great, well thank you so very much and thanks everybody for making so much time. Thanks very, very much to the NQS staff and leadership for, you know, all the hard work that goes into this. I think the one thing I would just lead off with before turning it over to (Margaret) that I think will be helpful is within the seven proposed subdomains that are listed on Slide 17 and 18 so communication, establishing functional staffing plans and support plans for staff and volunteers, training plans for staff, staff and volunteer recruitment, safety, coordination and response across the continuum of care and the data and quantification, those seven subdomains really are envisioned to try to be all inclusive in terms of any measures that we think are relevant in terms of staffing issues related to emergency preparedness.

And so if there are gaps I think as was nicely said before this is the time to mention that. So all of those little double arrow bullet points that are examples below are simply examples. They are not meant to be comprehensive. They're not the subdomains but if things that are the boxes of those seven that are missing I think we'd really love to hear that or love to hear examples of something that people think are that's maybe either controversial or challenging and a discussion of which subdomain is most relevant for a topic that we think we have to consider. So I don't know (Margaret) what else, did you have other things to add? (Margaret) are you on mute by chance?

(Tina): All right we are not seeing any hands. I'm curious does anyone want to make a comment? Oh we have a hand. Okay (Jennifer Greene), we actually realize that the Webinar does not match your name. Oh it does. Would you mind just unmuting (Jennifer)?

(Jennifer Greene): Yes I unmuted now.

(Tina): Okay.

(Jennifer Greene): So the correct - you can hear me okay correct?

(Tina): Yes go ahead.

(Jennifer Greene): Okay. My or question or thought actually kind of slides back into the point that (Marcie) made during our guiding principles as to where does the group fit in for staff with the scope of practice. So, you know, in terms of thinking about who retention is and how it speaks to this training whether or not like I think about an example of either within a nursing staff capacity or even from an at risk population. So for example if you have a preparedness component with someone who is suffering from an addiction and, you know, the different, you know, it can be very different between a clinical staff whether that's nursing or behavioral health intervening whether somebody's got that background in, you know, in addiction or not. And so, you know, we've got recruitment registration and retention but in terms of noting scope of practice in there somewhere I'm not sure where to fit it, but I do feel like it needs to be addressed.

(Paul Bettinger): Yes I like that - this is (Paul). I like that comment a lot and I think it needs some thought about both considering, you know, appropriateness of the use of staff for the disaster situation and probably, you know, also of course touches

on the crisis standards of care question in the subdomain of coordination in response across the continuum of care so definitely a good one. I think the other thing your next question certainly raises is the fact that there will be some overlap that certain questions or concerns might be addressed by two different or three different subdomains at the same time.

(Tina): All right (Margaret) are you able to speak now? We did receive a chat, so you may not be able to - your unmuted but we can't hear you? Okay…

Woman: Or she can press Star 7.

(Tina): Try pushing Star 7 if you can get unmuted but in the meantime (Paul) why don't we have you take lead of this one. So you know (Mark) and then (Steven) are in line. So if (Mark) you want to unmute yourself? And you just hit Star 7 (unintelligible).

(Mark Jarrett): Right, okay. Can you hear me now?

(Tina): Perfect thank you.

(Mark Jarrett): Okay so a couple of comments. First just as a matter of emergency preparedness I put staff safety as the first bullet rather than communication. I think that that's just the right way to do things in always protecting your staff. Number two is the issue in scope of practice you go to volunteer recruitment. Now do you mean volunteer from within your staff or do you mean from the outside volunteer because that gets to the issue of licensure, et cetera, and (unintelligible) which is a whole other issue.

And then under established training plans I know you have behavioral health issues. I know these just a sub points and temporary shelter staff. I'd include

in that pediatrics because that's something everybody kind of tends to forget about. And pediatric patients in a disaster are very different than adult patients namely because of the fact that parents aren't around or may be around or how do you handle that especially if you're evacuating a hospital parents become really kind of critical.

And the final thing is under staff and retention, just the concept somewhere in that bullet that we have to think about family support, people stayed in an emergency because they know their families either can come there and get protected or some other, you know, explanation. But I think we have to include that as a measurement because otherwise you don't retain staff in an emergency. They're running home to take care of their family because they feel there's nobody else to do it so just some concept around that maybe to be in there.

(Paul Bettinger): Yes I think all great points and I think yes everybody who's got, you know, emergency management, blood, putting safety up front certainly is a great concept. I think, you know, in terms of the training question, you know, I think you're absolutely right with behavioral health and adding pediatric to it. I think, you know, in other conversation we've talked about, you know, just in time, a lot of things coming under just-in-time training or in at least a small amount of pre-event training or priming for folks in, you know, burn management or things where again skill sets are going to be relatively thinly stretched so I like that a lot.

I think the vision was absolutely as you said that under, you know, staff recruitment registration retention is family support. And I think it's also other kinds of personal support. So, you know, for example the area has been affected by a hurricane and people have to go home to pump out their basement or go take care of their mother or, you know, go take down the wet

drywall before the house gets moldy and kind of all those considerations including, you know, having staff sleep on site at the hospital are all kind of falling in the bucket so I think definitely very good comments. All right for the NQF folks I can't actually see who's got a comment in line so if you don't mind just keep calling on folks to have them go next. Unfortunately I can't get that from my screen.

(Tina): No worries. So (Steve) you're next and then (Lucy) we have you after him. So (Steve) if you could unmute. And that's Star…

(Steve Cruise): Hello. Hello does that work?

(Tina): There you go.

(Paul Bettinger): Yes now we hear you.

(Steve Cruise): Oh perfect great. So good afternoon everybody. And kudos to (Mark) for those comments. I love it when somebody else brings up kids. Another endorsement for putting safety in here somewhere because I think that's a key. And aligned to that and (Mark)'s already made the point, one thing to measure that actually might promote the ability of staff and volunteers to actually agree to respond and deploy is whether they have family and/or personal readiness planning because those are the people that are going to be more willing to hang out and help as opposed to running home. I know that you got in the next subdomain or next domain of communication but under the communication bullet don't you mean health system as opposed to hospital-wide? And I believe using health system as a proxy not just for, you know, the XYZ healthcare system but really healthcare everything, everybody who is engaged in healthcare is being part of a health care system whether it's a, you know, a formal one or not.

Under the second bullet we want to systematically test, not just surge capacity but also capabilities. And that more the issue of things like pediatrics comes into play. And I think just-in-time training is ultimately the way the providers are going to get better at that. But, you know, if we're expanding critical surge capacity and there's too many kids for the pediatric critical care beds in the region and the staff are going to have to be prepared to take care of kids. And a lot of that maybe just-in-time training or telemedicine support but some of that's just planning in advance for that so it's just not numbers of patients but types of patients.

And again maybe this is more of a generic comment, when we say ongoing training under the third bullet it's ongoing training for what? And I think this document will be especially helpful if it offers specific examples of things that either are out there and represent the potential idolized practices or things that whoever's going to be using this – the tools to drive improvement and again under evacuation consider providing examples, not just specific to hospital evacuation and facility evacuation but also for evacuation of specific types of units where they also might be high risk patients like a newborn intensive care unit or a cardiac critical care unit, et cetera, et cetera, but the - again, overall good work here guys. Thanks for the opportunity to comment.

(Paul Bettinger): Thanks definitely for all that, I think great points. So one comment I just make to add on to what you said is something probably most many of you are thinking which is communication is clearly a subdomain in each of the domains, just of course we all know that communication is by far one of the biggest challenges and needs for good plans and good systems in any emergency, so the communication subdomain within staff really focuses on how do staff who are responding receive appropriate communications and are able to communicate in order to do their job? So that means certainly within

the healthcare entity their work begin whether it's a clinic or a hospital or any other healthcare setting but then also, you know, how are entities able broadly to communicate with their staff to coordinate action to make sure that the response is moving effectively? So that will be different than communication related to use of supplies or the structured business to others that we'll talk about when we get to the next domains, but just thought I'd clarify that. And maybe kind of check one more time, (Margaret) are you unmuted by chance? Okay we'll keep going on.

(Tina): Okay so now we have (Lucy) your hand is down so I don't know if I actually put it down or if you no longer wanted to make a comment? All right, Star, - reminder Star 7 to unmute.

(Lucy Savis): I'm sorry, can you let me now?

(Tina): Yes go for it.

(Lucy Savis): I - so I actually put my hand down because between (Mark) and the last speaker you pretty much covered all my points, so thank you. But I do think when we think about communication, especially the point that was made with the use of the term health system of any entity, because in surge capacity a lot of times you're going to be trying to keep people out of hospitals and using other resources like skilled nursing facilities and other kinds of facilities. And so thinking about those internal communications versus the external communications will be important. And then I love the idea of making (Stacy) prominent as well as the family plans. And I think about a lot of the work that UPMC did early on after 9/11 as an exemplar of that so thank you.

(Paul Bettinger): Great, thank you.

(Tina): Great. Then you have (David) and (Jennifer). I mean (Caitlin) you put your hand down so if you do want to speak please put your hand up but otherwise I'm going to assume that you also like to - already made your - already heard your points made so you didn't have anything to add. But (David) you're next and then after that (Jennifer). (David)? Star 7 please.

((Crosstalk))

Man: (David) we can't hear you.

(Tina): All right, okay well why don't we just go to (Jennifer) and then hopefully (David) can speak after that. (Jennifer) do you mind making your point now?

(Jennifer Greene): Okay thank you. And I'm not sure if we're ready for this or not yet. My question had to do with the part about how did the subdomains fit into the four phases? With the way that we have the wording for like the establishing testing and activating subdomain and the recruiting registration and retention terms of whether or not we word them still together because when we line it up where we are in the process for the mitigation preparedness response and all that, they would fit in different areas so I just had a question about whether or not we needed to look at wording it differently to lineup with where in the flow it fits or whether we have an expectation that there's a piece of that in each section of the process.

Operator: The conference has been unmuted.

(Tina): I'm hoping that'll help unmuting everyone. So (David) can you are you able to speak and now? Okay I think - I don't know what's wrong then with (David) and (Margaret)'s line. I apologize. Please go ahead and chat any comments that you want to make so we can read them out to you in the

meantime. So now after (Jennifer) we do have (June) and then (Marcie). (June) go ahead.

(June Kales): Okay yes under communication this is really across domains I believe. But what about messaging to the individuals that the systems work with related to placing or storing medications supplies, equipment, you know, where to go for alternative sites for infusion therapies or dialysis or what have you? It seems like it crosses domains but does it not go under communication?

(Paul Bettinger): So it's a great point. I think the current thought is there's no question that messaging to patients or if there's, you know, a different term that we end up using to, you know, anyone who needs medical care, you know, within the scope of this framework is really important that both pre-event, during event, post- event messaging and being able to communicate with them is extremely important. So the current thought is that it lives under the system domain and that make sure that the system is able to communicate with people. And that doesn't mean obviously just, you know, a state health department or a hospital ministration but that individual caregivers can communicate with their patients and clients. But right now I think that's where we have been talking about that living.

(June Kales): Okay, food for thought. Thanks.

(Paul Bettinger): Thank you.

(Marcie Ross): This is (Marcie). I believe I'm up next.

(Paul Bettinger): Yes please.

(Marcie Ross): Okay. So my role in being a part of this is to make sure that we're addressing 61 million Americans, 26% of the population people with disabilities most of whom need help maintenance and not medical care and those 61 million adults with disabilities and countless children and others have a legal right, have protection under federal laws. And I don't see in here anything that is going to drive planning efforts, implementation that will help the folks that are serving these folks to do it in a way that is within the legal obligation.

And so for example, one of the previous speakers very appropriately pointed to the use of skilled nursing facilities as an alternative to overcrowded hospitals. However people with disabilities have a legal right to protection from placement in more restrictive environments. And we're doing a disservice as we're putting all of this together if we're not doing an effective job of baking in explicitly that that needs to carry through.

So yes as we're talking about children and children have very specific needs we also need to be talking about people who have a legal right to certain kinds of health maintenance across this whole spectrum. So, you know, again my role, our role to keep coordinating that up and making sure that we can see it. And I don't yet see it in here.

(Paul Bettinger): So (Marcie) thank you so much for those comments. Can I just follow-up because we're obviously in the staff domain right now and when we start talking about some of the use of space in the system issues that touched directly on what you were mentioning in terms of where folks with healthcare maintenance needs get services and how the plans are designed to assure that they have access to appropriate health maintenance services.

In terms of staffing I just want to make sure I heard your comment correctly. Are you advocating for making sure that both within the training plans so an

ongoing training and just-in-time training that staff have appropriate training for how to support folks with disabilities and then also - our unit also belongs in other subdomains beyond that may be in, you know, coordination of response across the continuous care or I just want to make sure that I - we appropriate notice what subdomains you think are relevant here for staff related efforts.

(Marcie Ross): Thank you. And the answer is yes and yes. I think certainly in just-in-time training for staff critically important. We could have a whole conversation about what hasn't been working, what has been working and how important it is that we get this right. But yes it needs to be explicitly included in each of the domains.

(Paul Bettinger): Great. Thank you very much.

(Tina): Okay so then (Jennifer) your hand up again.

(Jennifer Greene): Ma'am thank you. I wanted to specifically follow up on (Marcie)'s point with I think I've got a good example from a staff training perspective with the human rights particularly with disabilities would be an example of uses involuntary commitment (laws) and the difference between clinicians making safety judgments again for staff and for patients by if someone's voluntarily seeking crisis care making sure reinforcing within either our subdomain and appropriate honoring of the person's one willingness to seek truth voluntarily but also willingness to refuse treatment voluntarily and making sure there's something in there that does not abuse taking away someone's right to make a decision about their level of care. And that would be…

Woman: Excellent example.

(Paul Bettinger): Great, yes, that's very helpful. Thank you very much.

(Tina): Okay so we don't have any more hands raised but we did have a comment come in from (David). Unfortunately we're not sure why (David) and (Margaret) aren't unable to speak on the line but he said that he wanted to point out that the ratio of staff for each facility needs to be considered. He does illustrate how many therapists to nurses to doctors to CT techs to patient are needed in a response and to what type of response. It is a (unintelligible) issue as there is no fixed ratios but a failure point in this results in a pinch point in a response. Ideally all providers practice center scope of practice and potentially beyond depending upon how hospital or state policy - depending on hospital or state policy.

How does that affect ratios and what are they? That's (David)'s comment. I don't know if any of you wanted to respond to that?

(Paul Bettinger): And this is (Paul). The only thing I would say is that I think that comment along with a couple of really, really good comments all tie into some capability issues and appropriateness of scope of practice and sort of the environmental practice that I think all are really going to be helpful to consider as we relook at the subdomains.

(Tina): Okay. So with that we don't have any raised hands. (Paul) it seems you're going to have to go solo on this one. (Margaret) we hope we can hear you soon but in the – should we move along to the next questions about the measure concepts then?

(Paul Bettinger): Yes, I think so.

(Tina): And (May) I know you're on the line. Can you just remind everyone when those measure concepts were sent out? There is a question that wasn't the one that was sent out on January 3. My memory's not that strong so I was hoping you would be able to tell us. In the meantime I'll read off some of the questions while you look up that exact date so people can have those measure concepts in front of them. But essentially the goal of this discussion is to create a list of measure concepts for each subdomain under the (unintelligible) domain. So we did is talk about those subdomains. Overall there seems to be our agreement with a couple of additions.

And the questions that we're really asking you to focus on are, are the measure concepts currently listed appropriate? Are there other measure concepts that should be included in the four phase model – preparedness, response, recovery and mitigation? Are these measure concepts scalable and generalizable enough for all hazards and what are other cost-cutting measure concepts that can apply to entities that deliver healthcare - that directly deliver healthcare services? (May) were you able to find the date of when we sent that email?

(May): Still looking for it.

(Tina): Okay. So in the meantime (Paul) do you want to start the discussion and everyone please raise your hand if you want to make a point.

(Paul Bettinger): Yes. So I think, you know, we obviously have the illustrative example of communication. And I think that's both good and challenging as several committee members have already identified that communication is probably the most crosscutting subdomain that will exist actually among multiple domains. But I think the question is exactly, you know, what was on the slide which is how do you think we're doing right now? How does the framework

look in terms of the measure concepts that are currently listed so you folks have to comment on that.

(Tina): Okay I'm seeing one hand up. (Marcie) is that from before or is this on this topic?

(Marcie Ross): This is (Marcie) and I took my hand down. Maybe I actually put it up after I put it down. Sorry about that.

(Tina): No worries. (Steve) you have a comment?

(Steve Cruise): Yes, can you guys hear me?

(Tina): Yes.

(Steve Cruise): Oh cool. Okay. So I mean again, I enjoyed the comments made by everybody and I think there may be some other things that might evolve here. I - this is a philosophical question which is so what degree of granularity are we trying to achieve with this and as an example ongoing training for what? And what is it if we're looking for metrics that we're going to ask health systems to evaluate and report on because not all training is necessarily going to be relevant to this.

I mean I think as an example besides sending your staff a survey and finding out whether they're eager to help out during a crisis is finding out whether they have a family and personal crisis plan because they still may not want to respond but that there's - it's more likely that they're going to be able to do that so that's a wonderful example of where we can go another step beyond what's on Pages 17 and 18.

(Paul Bettinger): Thanks. I think that's great. I think as far as I understand it, and the MQF staff may correct me right after this, but, you know, we're looking in terms of measure concepts to try and be really at least initially as broad and as comprehensive as possible so that, you know, it's easier to start big and call down later where there's overlap or where there's more than we need.

And I think, you know, the ongoing training is a great example of a really hard one. I think, you know, you – there's probably never been an emergency manager or an after action report that didn't suggest more training was needed and we'd love to have as much ongoing training as possible on every possible topic for every nurse, physician, respiratory therapist that could be involved in response. And yet all of us also know just how challenging it is to get, you know, any regular training for most medical staff in disaster response for - to have them read in a way we would like.

And so I think we're really looking to you all for feedback on the right level of granularity for these measured concepts about what really is relevant, what's appropriate for within the framework for measures of ongoing training, what could be, what should be offered, what's realistic, what's not and what, you know, what measure concepts belong in ongoing training versus just-in-time training. So I think that, you know, there's a balance between I think what should be asked or should be offered or should be required or should be measured of ongoing training related to emergency preparedness for health system staff and what just-in-time training should be offered and frankly, you know, what standards should that be held too. How are we going to measure the quality or the adequacy?

I think, you know, we've already had some great comments about very important populations, pediatrics, persons with disabilities. And I think, you know, this is where we're really looking to you for feedback as I say, probably

starting more broadly and more, and as comprehensively as possible and then reviewing that to narrow down to try and organize it within the framework.

(Jesse): This is (Jesse) (unintelligible) here just to, you know, just to let you know the source of these measured concepts were actually from the survey directly. So a lot of this stuff is very raw and sort of intended to be. You know, I think the, sort of the purpose like (Paul) said, this is sort of fodder for discussion at this point but these shouldn't be seen as, you know, these are the measures. These are just sort of ideas at this point that would need to be further developed into, you know, very specific measures with specific definitions.

But again sort of our ask now is to take a look at these measures and see whether or not we've missed anything or, you know, there are other areas or other sort of big concepts that we should pull in. And then we will also be doing some prioritization exercises with, you know, whatever sort of bigger listed measures come through. So in the end of this what this will look like is sort of a prioritized list of measures that should be, you know, high priority and potentially feasible.

(Mark Jarrett): Yes hi. This is (Mark). I just want to throw a concept out there that I don't know if it's applicable or people think it's a decent idea but - and I'll pick, you know, I'll pick training as an example but it may be applicable to other things, staffing - everything else. There's a level that we should be measuring for general training that, you know, everybody kind of needs a background or what, you know, what incident management is, et cetera and healthcare perceiving where they fit into that.

Then there's the training which really has to be the regular training has to be somewhat based on their, you know, on their HV, you know, their HVA. You know, out in New York. I don't have to worry about earthquakes but I do have

to worry about hurricanes. So there's the concept of what the training is for an event that will have the impact and more likely to occur will be different on the East Coast than the West Coast.

And then you can have the third level of training which is the just in time for those things that are much less likely to happen and are going to require really specialized training that nobody's going to retain because hopefully it won't happen for five years or ten years or forever. But I think we need to kind of break it down in that regard so that it's not generalized just training but specifically tied to the risks that are in that area or for that health system or for that hospital based on geography and everything else going on versus just saying it generically training so we can measure more specifically based on the different level.

(Paul Bettinger): That's really helpful I think if I may, if folks haven't checked their email and (Jeffrey) sent out that - the measure concepts now in a Word document and so to translate or see if translating what you said into a measure concept would be, you know, looking at the applicability of the specific training as related to the healthcare entities hazard vulnerability analysis just to make sure that it's appropriate, the training's offered are well matched. Is that what you're getting at?

(Mark Jarrett): Yes exactly.

(Paul Bettinger): Great, thank you.

(Tina): Yes I think we need the - for some reason it (unintelligible) doesn't make sense or it was so long ago that none of us really remember anymore. So hopefully you have received the email with the list of measure concepts that

we did come up with. Please so free to open those measure concepts and read through them real quickly. But if you have any comments let us know.

We are showing no hands on the Webinar so if there is something you would like to comment on please let us know. I'm just going to let - give everybody just a minute or two to read through it real quick just for the staff portion in case you weren't able to read it earlier. Okay (Jennifer) you have your hand raised?

(Jennifer Greene): Yes thank you. I in looking at the measure like for response measure in terms of response time for staff but going actually back to the example I think about the hurricane that came through North Carolina most recently. And, you know, we had, you know, two and three hours of travel time for - so that staff that were, you know, providing support, on our case that was to be able to support provider, you know, authorizations and be able to maintain support for the direct providers so they could, you know, go respond to their homes. But in terms of factoring in there, depending on the region we're talking about response time for our trained staff. Some states, you know, like North Carolina is 100 counties and eight hours wide versus New Jersey is, you know, 90 minutes wide. In terms of where supports are coming from, we had - North Carolina had a response coming from Virginia, Tennessee but also up in Delaware so phasing that into the access to the staff that we'll need being factored into a response measure.

(Paul Bettinger): Great. That's definitely a good comment. I think, you know, BG it's not just I think the geography which is a really good point you make but also type of events and type of response needed right, so that if there's a large staff mobilization for a no notice mass casualty or other event that's a different kind of staff response time than for a sustained events, you know, as you're describing both in sort of the early and the later phases of the response so we

may have to think about the event characteristics where the need to look at staff response time changes. Other comments?

(Mark Jarrett): This is (Mark) again and I apologize to be so verbal today. The other - you know, going back to a comment somebody else that made it very early on these are all lot of structural and somewhat process measures. I think for staffing you need an outcome measure based on the annual exercise that you do or the biannual exercise you do to see if what you thought you did really worked. There has to be, you know, you can't wait for an outcome from the event but you can still do it, you know, you can do that but you clearly can do it with your exercise once a year to see if things you put into place really stuck and worked. There's got to be an outcome. It can't just be that you, you know, that we check off the boxes we did X, Y, and Z because we do that too much of medicine.

(Paul Bettinger): Yes, no I strongly agree with that. I think, you know, that it was stated, (Mark Cozey) that made the comment and I definitely agree that, you know, outcomes do we actually have an appropriately trained staff who are willing, able and actually do show up in a timely fashion is really important and either in real-world events as we experience them or as you say with, you know, various proxy measures and exercises others that we drill down and make sure that that actually is true.

(Tina): All right, thank you. (June) you have your hand raised?

(June Kales): Yes. Can you hear me?

(Paul Bettinger): Yes thank you.

(June Kales): Hello?

Woman: Okay go ahead.

(June Kales): Yes I thought a lot about this training. Unfortunately I haven't seen in that handout just before so you haven't read it very thoroughly. But you said we need to apply the filter of knowing that in these health systems training time is at a premium and we just don't get much of it across these systems. So I think measures may have to focus on the quality and the timeliness of the just in time training products and that they indeed have been tested for clearness.

And I think the other thing that we often forget that is more of a heavy lift is how do we imbed these issues into the regular competency trainings the staff has to already do so it's not seen as separate but it's part of, part of the whole system of competencies because I think the other part about just strictly invest just in time training if my experience is in the disability world is that the people we train today, they're not there tomorrow when they really need to apply this. So I think that equal if not more attention has to be paid to the just in time product than the overall, you know, one and done training that misses the whole lot of people who actually become the responders.

(Paul Bettinger): So in your comment is there the idea that when we don't just say for example, you know, staff training on disability care for disasters but we put in some gradations that there's a, an awareness level training, an operational level training, a mastery level training and we look at, you know, measuring percentage of staff who are trained to each level rather than just saying yes, no it's more binary whether there is training? Is that something that is kind of what you're suggesting?

(June Kales): I think we could go deep into all of those answers but basically, you know, is the training does it consistent how do we do this? And if I forget how we do

this is there training over an intranet or something I can go to, to find what I forgot so assessing checklist that reminds me what needs to get done because just checking a box that I went to one general training, you know, last May just doesn't seem to do it.

(Paul Bettinger): Great.

(June Kales): I think we really need to go deep into this one at some point because there's a lot of nuances to what's really working out there and what's just kind of a check the box but it's meaningless.

(Paul Bettinger): Yes I think, you know, the need to figure out the effectiveness or again back to the outcomes question of does the training create the capability that we desire which is the ability to effectively care for persons with disabilities for example is important. And I think just check in the box to say everyone was offered a PowerPoint presentation on caring for persons with disabilities is very different than actually providing care and thinking about how the measure concepts account for I guess is a good point.

(Tina): All right (Lucy) you have your hand up and then (Barbara) will go to you after (Lucy).

(Lucy Savis): Yes can you hear me?

(Paul Bettinger): Yes thank you.

(Lucy Savis): Okay. I really appreciate the discussion that just occurred. And I think the other thing to keep in mind as we think about training is the cost of training to these healthcare entities. In many cases -- and it varies by system -- but we have to pay staff time for that training. So not only does it need to be

effective, not only do they have to have access to refresher training and the ability to, you know, orient new staff but the cost of the actual systems of adopting additional training requirements.

(Tina): (Barbara)?

(Barbara Siderella): Can you hear me?

(Paul Bettinger): Yes.

(Barbara Siderella): First of all great conversation. Thank you everybody for all your comments. One of the issues that keeps going through my head as I'm listening to this conversation and we're talking about training and staff. I think we need to be cognizant of the fact that the members of the healthcare system are functioning all at different levels and don't even speak the same language. So if you take the outpatient providers, not everyone is as savvy or as trained as facility based. And I think that's an issue we need to be cognizant of and look at when we're talking about staff preparedness. That's my comment.

(Paul Bettinger): Yes I think it's really – what, you know, if we're trying to use the framework to think about how we measure the readiness of the health system I think, you know, obviously what we're trying to do is figure out if the health system is ready using the various different kinds of providers with different kinds of training to rise to the challenge of what the clinical and other needs are for patients. Is there a way that you think, you know, within either the measure concepts or in the subdomains we've listed that we should be thinking about how we're trying to create a common capability among staff with very disparate levels of experience and training?

(Tina): Thank you (Paul). We have one more hand raised, (Colin).

(Colin Case): Hi, thank you. On the same note really is a complexity of training and that a paramedic needs something different than a nurse versus a physician versus someone in the administrative staff and then keeping in mind that when we're talking about, you know, catastrophic situations that housekeeping and security staff probably need some training too so they're aware of what's going and what may happen or what is happening at the time is it just in time. Thank you.

(Paul Bettinger): Great, thank you.

(Tina): Okay I'm not seeing any other hands raises for this one. I think this kind of covers the measures and measure concept - measure concepts and measures part. I know that unfortunately people didn't have access to that list earlier and we can always try to – you can always provide us some feedback in email.

Before we jump to supplies the next domain, I did want to ask one more question going back to the subdomains and around that last bullet of how to do the subdomains fit into the four-phase model. Mainly around do we feel that all the subdomains that are listed and some of the ones that we mentioned need to be added they fit into every single phase. So does it fit in mitigation and preparedness and recovery and response or is it that one - certain ones are only suited for certain phases while others are not? And that obviously even if we do say that all the subdomains are appropriate for all additional phases we would have measures that would differ under each subdomain for that phase. So I did want to make sure to ask if we feel all subdomains apply to all phases and if there's anything that needs to be adjusted when we think about that moving forward?

And then (Colin) I still see your hand raised. I'm assuming that's left over from earlier yes. (Unintelligible) it's down. All right (Steve) you had a comment?

(Steven Cruise): Yes can you hear me?

(Paul Bettinger): Yes.

(Steven Cruise): Oh cool okay. Oh even better. I mean in a perfect world each of these subdomains would fit all those four phases but I think some are going to be more impactful in readiness, some more in response and then some specific for mitigation. So as an example if you were drilling into training, you know, the availability of providers wherever they are in the systems to recognize mental health issues is going to be probably maximally leveraged well after the event has occurred. So I don't know that every component here needs to hit all four areas. I mean what you may then do once we're done with this exercise is you might actually go through an exercise where you try and align the various subdomains and potential metrics and see how they fall in to those four response areas or four pages of disaster so to speak.

(Paul Bettinger): Oka, thank you.

(Tina): All right (Kimberly) I've seen your hand raised so I'll go down so you may have another point to make. (Scott)?

(Scott Aronson): Hi. Can you hear me now?

(Tina): Yes thank you.

(Scott Aronson): Great. So I just wanted to echo that a bit. I think that when you get into certain elements that it's important that we break them - that we do break them into the phases. When we look at training for example, just in time training is typically going to be associated with the response. And then your preparation training and everything else that you're during is typically going to be associated with that aspect of the preparation, so all the major levels of it because you're identifying the problem in mitigation you then or identifying the fix, you're working on in preparedness and then the response level is when we're actually doing it. So I think it's important that we do phase things appropriately because I looking at this from a standpoint of being someone who receives this on the backend instead of hey here's a framework for you. I just don't want to see the same thing replicated in each area. I'd rather see a broken down to how the mindset has to operate within each of the four phases.

(Paul Bettinger): Thanks (Scott).

(Tina): Okay I'm not seeing any more comments. (Bigela) did you have a comment to make?

(Bigela): Yes thank you. I just figured out how that works, Sorry about that. But I really agree with what the last speaker just said. I think that we have to once we've kind of gone through the first level, you know, differentiate each of the subdomains across the domains there's going to be some overlap. And, you know, I'm sort of sitting here making tables with columns and Venn diagrams as alternate ways to display that but I do think that that's going to be really important because what we have to be thinking is exactly what the last speaker just said. And I'm sorry I don't know who that was but this how does this get operationalized and how does it get implemented and used and so we really have to have something structured for people to be able to optimize how they do that.

Man: Great, thank you very much.

(Tina): Okay. No other comments at this point. I'm not seeing anything in chat. (Margaret) did give us an example that we'll be incorporating but nothing that I think we read out loud. So I will give everyone one last chance. If you want to make any more comments on staff, obviously again not your last chance ever. We will continue to talk about this but in terms of at least giving staff your - a starting point for which we can continue to build upon. So any less comments on staff? Otherwise we can move on to supplies?

All right and, you know, initially we had thought we would take a little longer with that and I am super pleased that we were able to get through it so quickly. But I think let's just take a moment to see if any public members are on if you want to make any comments about the staff portion. Okay I'm not hearing anything. We can move forward.

So now we're going to jump into supplies. It's going to be the same set up as staff was. So essentially the subdomains we have under here are four, so documentation and inventory and supply change, assessment of supply chain, surge capacity and then community and provider pharmaceutical access at 100% capacity. Those are the four subdomains that we pulled from the assignment that we asked you to do.

Again all the sub bullets are just kind of for our own use and your use to understand what we mean by each one of those categories. And now hopefully everyone has that measure concept document. And you can see that we did name a couple concepts there. So as we did with the last discussion we will talk about the subdomains first to make sure that there is none that you think

should be removed, or if there's anything that's missing and then also about how we feel they fit into the four-phase model.

It seemed that based on the last discussion if we go in the same trend as the staff, one it seems appropriate to keep the subdomains but then maybe instead of doing by phase breaking it down by sub domain and then phase to help someone have a continuous view of exactly what they need to be doing in order to achieve that subdomain. And so with that I'll give it to (Paul). Actually let's check to see if (Margaret) is able to speak. Hopefully we're able to get her. (Margaret) are you on the - can you speak on the line?

(Margaret Wilson): Can you hear me?

(Tina): Yes we can.

(Paul Bettinger): Yes.

(Margaret Wilson): Oh wonderful. Thank you...

(Tina): Oh (unintelligible).

((Crosstalk))

(Margaret Wilson): ...so much. I - you know, was afraid to dive in there but I'm glad that you can actually hear me.

(Tina): Yes. We're grateful to have you be able to speak. So did you want to start the discussion?

(Margaret Wilson): Sure, absolutely. So in this particular subdomain we're looking at the list. I don't know if you've had a chance to look through them but just wondering kind of where, let's just start the discussion and take some feedback around the information that you have already provided to us.

(Tina): Okay.

(Margaret Wilson): And I can't see anybody raised hand either on my end.

(Tina): (Unintelligible) Yes I will continue to say the names. (Barbara), do you still have your hand up or is that from before?

(Barbara Siderella): No I did have my hand up. Thank you very much. I have kind of a threshold question and maybe I've missed it but this domain is now called supplies. And that's what I believe was previously called stuff, is that right?

(Tina): Yes that's correct.

(Barbara Siderella): And so then I do have a question because I can certainly appreciate that people might have felt that stuff was either too colloquial or not well-defined enough but as I've, you know, began to look through the supplies concept it seemed to me much narrower and might prevent us from considering a broader range of statements that aren't staff structure or systems but more broadly stuff other than just supplies. And so I wondered if you might comment on that please? Thank you.

(Margaret Wilson): Just to give you some feedback on that. Can you give us some examples of what you would like to see included that were not listed?

(Barbara Siderella): Well I guess if you - and maybe I'm reading this too narrowly but I guess as I was reading this and even thinking about supply chain and, you know, some search issues and the pharmaceutical discussion, for example equipment which didn't really seem to be addressed here it's not exactly infrastructure, it's not exactly systems but really to me would seem to fit more under stuff and so I've wondered about that. It was for example a huge issue with organizations that we worked with in Puerto Rico. So that's kind of where I was going with this.

(Margaret Wilson): Thank you. We're (unintelligible) thank you so much. I'm just wondering from the (NQF) team, can you give us a little bit of the rationale that for the switch between from stuff to supplies?

Woman: Yes sure. It - so I think part of it was that stuff seemed to colloquial as sort of a big category. So we went to supplies. And when we were thinking about it, I mean in a way supplies can also be sort of access to machines as well as meds as, you know, a lot of different things could be supplies, bandages. So way wanted to sort of make it more - maybe put some more parameters around it and make it sort of clearer. And stuff could be anything. I mean a chair could be a stuff but we wanted to make sure that the stuff we're talking about is like really focused on like things that we would need for an emergency.

But we do sort of, you know, hear the discussion and we can definitely take it back and sort of revisit is it stuff or is it supplies? And if it's stuff then other than everything that's listed here what else could and should be included in stuff is a question that then staff would put back on the committee.

(Barbara Siderella): Thank you.

((Crosstalk))

(Barbara Siderella): I – oh I'm sorry. I was just going to, you know, say I really appreciate that and thank you for explaining that. It may be that as we look at the measure concepts and the potential measure themselves that that'll help but I - that clarification was helpful - appreciate that.

(Tina): And this is (unintelligible). You're dealing with the subdomains that we have right now are making it seem like all of the other things are not options. You know, this is the point of having this discussion so we can make sure to add those subdomains and subcategories that you think are important. With that in mind I want to go through, we have kind of a (unintelligible) people want to talk so very excited. (Mark) you're our next in line so just. So everyone knows we then have (Scott), (Steve), (Caitlin) and the (June). So (Mark) you want to go ahead?

(Mark Jarrett): Sure just one thought again about your stuff and supplies and I agree with the comments that were made. You know, maybe you want to, you know, use any more logistics type thing and materials or whatever. And you talk about it's not just things that are in the hospital. You may need transport vehicles. Do you have enough of those? Do you have major transports? I mean I evacuate my hospital and in hurricane we use city buses. I mean this - you've got to think, you know, beyond just - that's why although stuff is not a very scientific term it's somewhat useful.

The other question I had was under mitigation measure concepts for example having 100% of consumable supplies, 100% of what? I mean is that a normal usage? What happens if you have surge plus you're not going to get resupplied for three or four days? I just worry about having that, you know, again you need an evaluation of what your supplies need to be at what level

for an emergency, not your normal levels so that has to be figured in somehow.

(Tina): Thank you (Mark). That's a great example.

Woman: (Unintelligible) for those contents.

((Crosstalk))

(Tina): Hold onto it for the measure concept section when we get there. Sorry did - (Margaret) did you want to say something?

(Margaret Wilson): No I just think him for his comments and wondering who is up next?

(Tina): Yes so...

(Scott Aronson): Sure yes this is (Scott Aronson).

(Tina): (Unintelligible).

((Crosstalk))

(Scott Aronson): So and (Mark) I actually could address that because I just put that one in. Those really addressing the consumable supply verifications expiration dates done annually. That was on the preparation side due to so many institutions having out of date product. And that's what that was referencing. But I want to come back on a couple things as we go through this. So I also agreed with the supplies being too limiting because we - when we talked about that we're usually talking about equipment supplies, meds so pharma. And those are the

broader base. When you do use the term supply it just narrows it down in the general visualization of it.

I was looking at two components in here. One is should we be adding on evacuation into here? So when we're dealing with the evacuation we have transportation elements that are going on and I think (Mark) also brought that piece up. We've got the security of what is being moved so if we're moving volumes of pharmaceutical or other things that are necessary. So there are some components there that may be for consideration.

And as we get into the surge capacity so we've done probably 500, 600 hospitals for surge capacity catastrophic assessments. And what I think is critical as we drill down into these subdomains is really looking into all of this again coming back to why equipment is so important here. We're talking about splitters for oxygen, portable suction. We've got so many components for the beds or stretchers that need to come in. So I think those will be good drill downs as we get into there.

Why I'm such a huge advocate on the surge capacity side is that it's one of those things, it's always a challenge when you think about emergency management and you take into account what happens with the fire service. So the fire service has to go to a different building or entity or organization every single day. They're dealing with different structures. They have to get there and rapidly assess the situation and make decisions.

In the healthcare structure in the in-home structure whichever may be you're dealing with a known entity. And one of the challenges here is that the hospitals really can get a very concrete base of what they need in order to surge -- the staff, the supplies, the equipment the everything that's necessary to accomplish a surge whether it be a mass influx, mass casualty, a burn

situation, another hospital evacuating or healthcare facility so you really can get a really good base on that yet everybody goes off of percentages and numbers and doesn't really come down to that granular level. And I guess that one part that I would see in here is how do we take some of these pieces? We've got the coalition surge test, we've got all of those things happening. How do we take some of these and help people get a very clear framework? They're not going to have the extra 120 beds they may need or 250 beds they need to do it. But as a health care system readiness I want to know exactly what I would need if I go to a full breakpoint and exactly the staff and other things I may need so that that would enable us to make decisions as coalitions, as regions and things like that. So I think it's important that this information that can be gathered from a healthcare system readiness can then roll up really nicely into how these - how the coalitions and states operate to support it if we get to some of that granularity. That's all I have.

(Margaret Wilson): Thank you. I think that's actually a really great point as we look at it from the system approach. Thank you for your comment.

(Tina): Okay (Steve) and then (Caitlin).

(Steven Cruise): Hey hi. this is (Steve Cruise). You can hear me okay?

(Tina): Yes.

(Steven Cruise): Cool thanks, again great comments including the last comments are excellent. You know, supplies is a better name than stuff. Stuff doesn't sound like that means anything although if you're in disaster medicine you know what we're talking about. But I would be as descriptive as you possibly can be. So I would call this medications equipment and supplies. But that's, you know, that's just my minor opinion.

Surge capacity is important. You know, I probably will continue to say this but surge capability is as important. So can you take care of 20 more patients in your ICU but can you take care of any kids in your ICU? And part of that's a staff thing right, that your staff has the appropriate training whether it's in advance or just-in-time. But you have the right stuff? Do you have a 3.5 in a tracheal tube and do you have more than one 3.5 in a tracheal tube? And these are the things that are they available within the national stockpile? They're not going to be available to you right away which means if you don't have it the patients are going to die.

So this needs to - you wonderfully brought this down into four bullet points which is amazing but it's much more complex than these four bullet points. I mean diagnostic equipment is key and it's not just having certain critical medications and your – in your in-house pharmacy and whatever's out here in the strategic national stockpile and in advance packaging in cities and whatnot but whether you've got the right formulation so that you can take care of all populations. Again these are key differences so not all humans are the same and we really want our healthcare delivery system to be prepared for the community that it serves.

And on a day to day basis that large healthcare system might do very little pediatric care but they then might find themselves having to provide for care or for other at risk populations. So I would - I think there needs to be a little more flushing out of this. So again it's a great start. Thanks.

(Tina): Thank you. Next is (Caitlin).

(Caitlin Derve): Hi guys. I agree too. I think all the comments that have been made are great and I think it helps us really maybe define this area more because I was trying

to think of another word and I - the only thing I could think of was resources but kind of I guess it would be nonhuman resources because I agree, not only just the supplies and, you know, Foley catheters, things like that but I was also thinking of the supplies you're going to need for your staff.

One of the big things we have run into with hurricanes has been having enough food stored and water in case we have power outages. In other living needs we have these kitty litter toilets that we have stored away. So trying to broaden this and as much as since I'm the pharmacist on the call I like to focus on medications. I do recognize there's a lot of other things we need.

The other thing that I was thinking of was for the domain. I feel like maybe a domain of storage and safety because most of us for the suppliers that we would truly need for say planning for five to seven days and now after Sandy we all plan even longer than we initially did which used to be like three or four days. I think finding, having people with the thought process that it needs to be stored and it needs to be safe for fitting it all we have off-site storage for a lot of our stuff or have plans to bring in a certain percentage with access to more at a certain point and then also that it is safely stored and if it's food or medications you cannot just store that anywhere so something related to that.

My last comment was the last bullet community and provider pharmaceutical access at 100%. I think this is getting at that we need to have everything available to try - that our goal should be we shouldn't have people go without. But I'd want to recommend not limiting this to pharmaceuticals. Things like nutrition supplies are important to healthcare. And then even the devices to provide these things, Foley catheters are important -- those things that patients might use on a chronic need basis.

For us just with the hurricane Maria and Puerto Rico being hit it wasn't just the saline that was the problem. Those manufacturing plants actually made the bags and the supplies needed to deliver the saline that we needed as a critical supply. So I think maybe broadening that last domain may help. And that's all.

(Tina): Great, thank you. Okay the next in line is (June).

(June Kales): Hi. (June Kales) here. What's missing for me is a broadening out is this area from not just in-house but outhouse, the supplies in terms or the stuff in terms of the community. You know, what are the systems doing and how do we measure this? How are they preparing the majority of people they serve who are actually living in the community, for example those who are power dependent as (unintelligible). That only – and the vendors. How are we intending to give people good options for power backup, preparing them so we're actually helping to decrease the served? Now what kind of protective measures are we helping the community to make? Who are these people who indeed, you know, depend on these life-sustaining equipment or supplies or medications, you know? What are we doing to get people to give medications early when there's warning and so how do we allow people to get enough trach tubes, enough feeding tubes, enough feeding supplies so they can make it, so they could shelter in place so they have what they need and respond on the same thing? How do we have people to quickly replace these equipment and meds before it becomes less threatening?

And then in recovery how do we have people to quickly get some of their customized equipment replaced? So that whole area is missing for me and, you know, for the majority of people are in the community who are using this stuff.

(Margaret Wilson): Thank you (June). I have a question for you just a log that train of thought. Do you have any thoughts on like specific subdomains that you're not seeing on the list that would apply in the community, things that you would like to add to that list? And you gave examples but are there categories or subdomains that you'd actually like to see added?

(June Kales): Okay so help me focus. I'm looking at the handout that we just – so which slide or which what - where are you in your question, which - are you looking at the subdomains here?

(Tina): This one right here where we listed out the five – four subdomains that we were initially considering. We obviously have heard a lot of additional subdomains that may be needed and we were hoping from based on your comments where you would see another subdomain (unintelligible). I believe (Margaret) that's what you're saying correct? (Margaret) did we lose you again?

((Crosstalk))

(June Kales): Okay that's (unintelligible).

(Tina): Yes we can hear you now.

(Margaret Wilson): Oh good okay yes. Yes that's exactly kind of what I was asking based on the current subdomains that we have on the list. I mean your points are well taken. I'm just wondering if you can help us formulate what another subdomain that would address those things might look like or sound (unintelligible).

(June Kales): Okay and that's Slide 26 correct?

(Tina): Yes.

(June Kales): Okay let me think on that.

(Tina): Okay thank you (June). While you're thinking about that we can go to (Nicolette) and then (Jay) had provided some comments in the chat out (unintelligible) out after (Nicolette). Go ahead.

(Nicolette Lousan): Hi everyone I definitely agree with a lot of what was already said and think that this is heading in the right direction but should be flushed out more. I would make a few suggestions on kind of how we're approaching the domains. One is that I think right now we've kind of conflated especially in the assessment of supply chain we've have conflated what the normal supply chain operations would or would have the capacity to do as it pertains to (Mark)'s point about resupplying things of that nature with what would happen through what we typically call the disaster supply chain, what would happen through the S&S capabilities and things of that nature.

And I think if we're going to do that we have to be very explicit about what would be expected from standard resupply versus the emergency measures that would be a downstream supply chain impact from government actions. So with that in mind I think we definitely need to separate those out in some way or be more explicit about how we're looking at what the private sector supply chain's going to do versus, you know, with the assistance of the S&S and other.

Also thought to that point is I think we on this document, I think we've got back and forth between medication and pharmaceutical. And I think we need to have some consistency there but also thinking about pharmaceutical and

medical material. And let's just be explicit about thinking about those supply chains together. And then I actually think having a domain on logistics might be the best way to think about how things are actually going to be moved. I'd be eager to hear what the group thinks about whether or not equipment could be included in that logistics piece but it's one thing to have sufficient products available. It's another thing to be able to get it in. And I do think we're going to have to look at that.

But last point I think is looking at the question of inventory. I think there's a difference between what should be on hand within the facility versus what is available in the supply chain or in the local supply chain. And we might need to be a bit more explicit about that. If we're talking about for example the issue of saline the issue was that there was a global shortage versus having a stop shortage because there's nothing at a location that could easily be moved in if logistics are not a problem. So I'm a bit more interested in kind of the latter of making sure that there is sufficient ability for resupply within the normal supply chain rather than focusing specifically on individual facilities inventory.

(Margaret Wilson): Thank you very much. I really like the point about logistics. I'd love to know what others think about adding that as part of this but I think it's a great idea.

(Tina): And (Margaret) before we jump to that I just want – that actually ties into (Jay)'s comment so I'll go ahead and read that out loud and then we'll open it up again to see what people's thoughts are.

(Margaret Wilson): Great.

((Crosstalk))

(Tina): (Unintelligible) he mentioned that maybe we should call this system logistics instead of stuff or supply as a different title. And then also wanted us to make sure that we're keeping things like contracts, contractors and vendors in mind which I think is something that's been stated before in terms of basically non-human resources that we might need. Okay so I'll go back to (Margaret)'s comment or the general discussion.

(Margaret Wilson): Is somebody else's hand up?

(Tina): (Steve)'s hand is up.

(Margaret Wilson): Okay let's go to the next person.

(Steven Cruise): Hey it's (Steve Cruise). I mean I completely agree, logistics is important and it's important enough to be listed separately because you could have all the stuff in the universe and then quickly run out of it or not know how to find it which isn't going to do you any good so I think it belongs on supplies. I mean it's, I mean if you consider food, I mean there's logistics with that as well, water, et cetera.

I really again think we should be precise. This is a place where we can talk about that there are components of supplies or stuff that need to be thoughtfully evaluated as part of how health systems are preparing for and evaluating their performance. And you do need medications, you do need supplies, you do need key pieces of equipment.

(Tina): And (Nikola) I see your head is up. I'm not sure if that's from just earlier?

(Nikola): It is. Taking it down now, sorry.

(Tina): No worries thank you. At this point I'm not seeing any other hands and we are about four minutes to close. Were there any final comments from (Paul) and (Margaret) that you wanted to make before we kind of next steps for tomorrow?

(Margaret Wilson): I just want to apologize to everyone I'm so sorry I missed a good portion of not being able to actually get on and be part of the conversation. So thank you for allowing me to do that at the back end of this. I really enjoy it and I think that comments today have been phenomenal. There's - it just really illustrates why bringing all of these diverse minds together because there's some great ideas here.

(Paul Bettinger): And I would completely echo that sentiment. Thank you so much.

(Tina): All right perfect. Thank you both and thank you to the full committee. So we're not done with supplies or what we decide to call it later. We can continue to that discussion. We have just gotten through the majority of the subdomains. We'll give you one more chance in the beginning of tomorrow's call to see if there's any subdomains that came to your mind while you were thinking about it. We'll jump into more measure concepts. You know, please look over that document that was sent to you that details the measure concepts we've up with so far based on what you've said and how to add to that or take some out or maybe refocus.

And we'll basically continue the conversation tomorrow. Were there any questions before we let you go? Okay and then as a reminder I believe the Webinar is different, the link yes?

Woman: The link is different.

(Tina): Yes.

Woman: It should be on your Outlook invite.

(Tina): Yes so please make sure to follow your Outlook invite to make sure you are dialing in and joining the right Webinar for day two. All right thank you everyone and…

(Margaret Wilson): Thank you.

(Tina): …we look forward to tomorrow. Bye-bye.

Operator: Thank you. Please stand by.

END