NATIONAL QUALITY FORUM

Moderator: Sheila Crawford
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11:35 am CT

(Margaret): All right I do not see any hands. So with that I'm going to turn it over to Dr. (Binninger) my co-chair. And we're going to dive into where we left off yesterday which was really looking at the measure concepts around supply or stuff.

(Punim): Sorry (unintelligible). Before we - sorry. We just realized that we did need to roll call before we continued with the call. Apologies we should have done that before I gave it over to you Do you might just bearing with us one second while we do that?

Dr. (Paul Binninger): Sure.

(Punim): All right I'm going to give it to (Nebiti) to do roll call.

(Nebiti) So (Paul) and (Margaret) I have marked you as present. (Scott Anderson)?

(Scott Anderson): I'm here.

(Nebiti): Thank you. (Sue Ann Bell)?

(Sue Ann Bell): Here.

(Nebiti): (Emily Terrier)? (Sean Case)?

(Sean Case): Here.

(Nebiti): (Barbara Cicerella)?

(Barbara Cicerella): I'm here.

(Nebiti): (Caitlin Durvey)?

(Caitlin Durvey): Here.

(Nebiti): (Alexander Garza)?

(Alexander Garza): Here.

(Nebiti): (Jennifer Greene)? (Angela Hewitt)?

(Angela Hewitt): Here.

(Nebiti): (Pegla Jacobs)?

(Pegla Jacobs): Here.

(Nebiti): (Mark Jay)?

(Mark Jay): I am here.

(Nebiti): (June Kale)?

(June Kale): Here.

(Nebiti): (Matthew Na).

(Matthew Na): Here.

(Nebiti): (Stacy Cokerum)?

(Stacy Cokerum): I'm here.

(Nebiti): (Stephen Crew)? (Nicolette Losey)? (David Marcozzi)?

(David Marcozzi): I'm on.

(Nebiti): (Glenn May)?

(Glenn May): Hi. This is (Glenn).

(Nebiti): (Gene Sakura)?

(Gene Sakura): I'm here.

(Nebiti): (Patrick Riley)?

(Patrick Riley): Here.

(Nebiti): (Margie Ross)?

(Margie Ross): Good afternoon.

(Nebiti): (Lucy Sabbath)?

(Lucy Sabbath): Present.

(Nebiti): (Jay Huron)?

(Jay Huron): I am here. Thank you.

(Nebiti): Thank you.

(Punim): Perfect, thank you so much. (Paul), back to you.

Dr. (Paul Binninger): Okay well thanks for everyone for coming back. And thank you to (Margaret) for kicking us off and obviously NQF team for such great work. Obviously without trying to make anyone dizzy I'm getting us up to the slides where we left off last for supplies and so just bear with me for one moment. You know, a couple of remarks as we get started and I think I'd like to start by inviting folks to comment again on the domain that as (Margaret) said is currently named supplies. I think as was pretty well stated yesterday by several people that the vision of this domain is that it includes all of the things needed to be able to deliver care to patients and so not just consumables certainly whether non-pharmaceutical or consumables but durable medical supplies and equipment I think absolutely fall into this domain.

And so the other comment I think or the other concept that was buried in some of the comments that I was hearing at the end were some questions related to supply chain meaning getting consumable or durable medical equipment from

point of manufacture or the distributors to the end-users so that they can deliver care but also the management of on-site inventory and on-site supplies. So, you know, there's certainly one question of getting it from where it starts to the person that's going to use it but also whether it's a hospital, or a clinic, or an aggregation of health system assets how they are using supplies as well.

And so I wanted to open up by asking if people had any thoughts or comments on the words that we're using right now with supply chain and whether that needs to be split out with supplies otherwise. And then as everyone knows there really are in a sense two kinds of supply chains one of which is the normal supply chain by which all normal medical supplies and resources are distributed and then there are the extraordinary supply chains such as the strategic national stockpile and others which are mobilized in time of crisis. And so if folks can raise hands we'll try our very best to call on you in order and kind of start with that, and (Colin) I see your hand is raised if you want to go ahead.

(Colin): Hi, thank you. So I guess like yesterday what I caught on this or took away was that we were looking at trying to change it to logistics which is a little bit broader than supply chain. So, or incorporating that into it. I'm just wondering if that changed as you guys were kicking around wording or because the supply chain is that, from the procurer to the procuree versus logistics is that plus a lot more.

Dr. (Paul Binninger): Yes. And thanks for raising that. I so I don't think anything has changed particularly. I think the current struggle is how much of that belongs in supplies which it may all belong here. I don't think anyone has suggested otherwise or how much of it belongs in system where, you know, there are obviously a lot of system planning interface issues. And so I don't know if you have a thought, or a comment or want to kind of mull that around a little

bit. This is, it's almost like communication where certain it goes among domains. Logistics in some ways spans that it is stuff and how you get there. And is how much of the how you get the stuff there is a systems issue versus a unique issue related to the domain of supplies so see if you have any thoughts before we move on?

(Colin): Yes, so I'm not sure I might, I'll need to mull that over. It might take us a day or so to come up with…

Dr. (Paul Binninger): Yes.

(Colin): ...anything tangible. But I guess my thought is it's, you know, from in response to your comment I think it comes down to, you know, what's our left and right limit so, you know, how far because you could slip further, you know, and get into, you know, business continuity or the resiliency of your suppliers. And I don't know that that's the direction that we want to go or maybe it is for, you know, an A plus, plus hospital or healthcare system. But, you know, there's, where do we cut it off I think maybe is where my initial thoughts are. So…

Dr. (Paul Binninger): Yes.

(Colin): … maybe supply chain is sufficient and going into logistics is taking it, you know, beyond the scope or the needs at this time for…

Dr. (Paul Binninger): I definitely don't think, yes thank you. I think that's really thoughtful. I definitely don't think it's beyond the scope. I think it's really a question of where it fits. So I'm really, really glad you raised it. And, you know, as it kicks around your brain a little bit please for free to email us or have a call because I think we're really eager. I think you raised it really nicely that, you

know, what are the limits, how far does this go, and how much does it start to touch business continuity planning or, you know, how deep does it go into the supply chain? When you're evaluating a hospital are they really, you know, responsible for measures of the manufacturing for the IV fluid bags as, you know, the example came up yesterday. So no I don't think anybody has a great idea but your comment was fantastic. Thank you. (Jim), I think you're up next and then (Jennifer).

(Jim): Can you hear me?

Dr. (Paul Binninger): Yes, thank you.

(Jim): I just wanted to add, and actually I was going to bring up the issue of business continuity so I'm glad that (Colin) did. And, you know, and again to the point you just made about where does it fall? I agree that there are systems that support this, the logistics of supply chain or supplies or equipment process. But I guess going back to the business continuity I just want to put a pitch in that at some point within this process of supplies whatever we call the section we need to consider that because, you know, the reality is that if hospitals don't have good business continuity plans and their suppliers don't then what does that mean well that it's significant impact.

And so the question I guess becomes for us so what does that mean for us? What would we expect as (Colin) said as the AAA rating because you have well-defined business continuity that's not only for your organization but for those that are, you are totally dependent on again (unintelligible) just throwing it out as more information if nothing else.

Dr. (Paul Binninger): Yes, I think that's, yes that's very helpful. Thanks (Jim). (Jennifer).

(Jennifer): And my point is a long the same lines as a good example that I didn't, wouldn't have been aware of except for what I've been involved in again in past, an impact of the hurricane that came through this past fall in North Carolina. I was part of what's called a (Med-assist) event where they do over the counter giveaways to help promote access for individuals who don't have insurance and that are indigent with over the counter medication as well as prescription medication.

And because they had their supplies had been going to the relief and impact that was going on in the eastern part of the coast, you know, most of their donations come from damaged boxes and access from pharmacies, CVS, Walgreens things like that. And the hurricane was having a ripple effect so that an event eight weeks later had the potential of not having the supplies they needed for more outreach and basically, you know, this is just basic medication. So in terms of, you know, from a scope or the supply readiness is, you know, had they thought out a plan and that may be more of a logistics but had the thought out a plan for how they fill in those supplies and that impact on the resources that are providing secondary assistance to the, you know, to, you know, to the direct patients that they're serving.

Dr. (Paul Binninger): Excellent a really, really helpful. Thank you. Other comments and while you're thinking I'm just going to move up to the committee discussion prompt. So are there any subdomains that are missing from the four that have been identified so far? So again we currently have indoctrination, documentation and inventory of supply chain, assessment of supply chain, surge capacity and community and provider pharmaceutical access at 100% capacity is the way they're phrased right now.

(Marcy): This is (Marcy). Did we want to add the community capacity for durable medical equipment into (movable) medical supplies?

Dr. (Paul Binninger): The potential, can I ask you say just to say a little bit more about that?

(Marcy): Sure. So, you know, there are many other resources that are utilized for providing durable medical equipment and consumable medical supplies through donations and donor systems that we operate. Do we want to include that or no?

Dr. (Paul Binninger): I think it makes sense too. I don't know if the NQF would want to comment more on that. But I think, you know, we want to be expensive and inclusive I think in this framework so that we're, you know, looking at all of the available supplies that either are required are available for effective response.

(Jesse): This is (Jesse) here. I guess the question would be would there be a quality measure that we could develop related to that?

(Marcy): This is (Marcy). And I think the quality measures could be around identifying what those other sources are and how those other sources are, you know, the coordination and the collaboration between the formal and less formal systems.

Dr. (Paul Binninger): Or (Marcy) if I may offer a friendly amendment is when we're evaluating a system is evaluating whether they have evaluated those resources, whether they've looked to map them out and whether they have an effective way to access them which would be a possible, you know, way to frame a measure does that make sense?

(Marcy): It does. That sounds like a great idea.

Dr. (Paul Binninger): Okay.

(Marcy): But so for instance if every state is required to have an assistive technology center most of those assisted technology centers participate in reuse. And most of them have emergency reuse programs. And, you know, hundreds of thousands of pieces of durable medical equipment and then countless pieces of consumable medical supplies are distributed through those processes through a program that operates out of Georgia Tech called the, Pass it on (unintelligible). So I think there are some measure, there are some opportunities for measurement along the way.

Dr. (Paul Binninger): Excellent. That's great, thank you. And (Jennifer) can I just double check. I see your hand raised. Is it just so we didn't take it down or did you have another comment?

(Jennifer): No I do have another, a comment on (Marcy)'s point or I guess it's more of a clarifying question. With the subdomain of documentation, inventory of supply chain does that include the storage of those supplies like in terms of how we are storing them what and with those practices that sit under here or different domain? And then one of the durable equipment type of examples or equipment (unintelligible) that I thought of is interpret, with expanding use of telemedicine as the goal but also for being able to provide (interpretive) services for different languages. I don't know whether there's a, I don't know what point falls under staff versus other supplies in terms of, you know, a specific component with those type of things that are going to be reused compared to things that are, you know, or like handing out walkers and, you know, meds and things like that the things that the staff needs to do their job, is there a distinction there?

Dr. (Paul Binninger): Yes I think those are both great points. I mean I certainly I think, you know, within the thoughts about supplies or stuff is again the equipment needs in order to be an effective with the capability. And so, you know, to have a plan for use of telephones for interpreters of telemedicine, you know, services if you don't actually have, you know, the phones, the iPads, the Internet that, you know, the technology, the durable devices that will allow you to communicate then it's not effective.

And so I think there certainly is a thought that that's included there. And so I think we, again the question is, is how do we within the framework think of measures of, you know, has a healthcare system planned for, does their plan, does their inventory adequately account for the need of the devices that they would require if they need tele interpreter, telemedicine services. And I think the other question, you know, your question about inventory is really important. You know, I think one of the things I find greatest, of greatest challenge of the supply of domain is the gulf between how medical systems on a daily basis manage supply with (unintelligible) inventory. And how in a disaster, you know, they may not be able to resupply to the same degree. And unfortunately that means that most medical systems have very, very little on hand inventory and actually very little space where they can stockpile inventory.

So I think inventory is an important consideration. If you have thoughts about what, you know, what measures of adequate inventory, or potential inventory or, you know, whether it's space or inventory systems I think we would definitely welcome your thoughts on, you know, what a framework or a measure of concept for inventory would be. And let me go to, I'm sorry I actually didn't pay attention between (June) and (Mark) who raised their hand first. But let me just go (June) and the (Mark) if I may.

(June Kale): Yes (June) here. I was just wondering where this goes. In terms of the supply chain it seems like it is facility based. And given for example this the final delivery needs to be to the person in the community for example via like safety check or whatever needs to get delivered directly to the person and that always just to the facility. Does that, is that an issue that belongs here or elsewhere?

((Crosstalk))

Dr. (Paul Binninger): So we were thinking say for the example of delivery of oxygen to someone who is on a home oxygen concentrator or home oxygen therapy. So making sure not just that it gets into the community but actually gets to the person who needs it is that correct?

(June Kale): Right. So the question is where does this supply chain end and what we're talking about? Does that mean at the facility or does it end at delivered to the person in need?

Dr. (Paul Binninger): Yes. So I think that's kind of what I was trying to hint at I think with the earlier comment that whether the supply needs to be used by a clinician in a hospital, or an office, or a long term care facility or whether it's needed by someone who is living at home in the community successfully but needs the supply in order to stay healthy and be able to stay at home I think this domain has to include delivery all the way to the end user. And that's where I was questioning whether we need a different wording or a different set of subdomains between the supply chain and delivery to the end-user.

(June Kale): Good. And…

Dr. (Paul Binninger): Yes.

(June Kale): …I just as a second issue I don't know went off this time or not but the wording of 100% I'm not totally understanding why is 100% is there and what we exactly mean? Do we know what we mean and is, does it belong there?

Dr. (Paul Binninger): I think that's a good question. I will definitely open it up to NQF folks or others. I think that one may be is reworded because I think, you know, came up because you said yesterday that whether it's 100% of demand or it's 100% of daily use and then we are asking whether we can surge beyond that. I think, you know, it may be in the measure concept which we're going to talk about in a second that, you know, actual percentages start to creep more into the measured concepts rather than into the domain, the subdomain itself. Yes thank you very much, (Mark) and then (Colin).

(Mark Jay): Yes. So two comments one was related a little bit to that 100% which we brought up yesterday because I was thinking about it more and when we think of supplies the inventory also has to include supplies that are needed for staff beyond food and water. So for example if your, if staff can't leave do they do have, do you have enough of the medications that they may need which they may not bring with them because simply they got caught in an event or they can't leave. Also there may be prophylactic antibiotics things like that because of the types of patients they're handling that they may need to be on that, you know, they and/or their families and that do and that you have to have an adequate supply of that. So that's why I worry a little about 100% because it's going to be more than 100%.

The other issue that I wanted to bring up is again this issue of facilities, the hospital facilities and their responsibility. I mean we always obviously take responsibility for our communities. But in reality and at least seen it in the New York area when we've had hurricanes and other things or power outages

the city and the state does take responsibility for delivery of oxygen and other things because quite frankly A, we may not have the means to deliver it and B, we may not have enough supply that we can give away supply so easily. That really has to come from somewhere else. So perhaps the metrics should be less around facility to people in their homes rather than rather, but rather be the identification of patients in our community or ways of identifying who do need that assistance and then a means of contacting the appropriate governmental resources to get those supplies delivered to them.

Dr. (Paul Binninger): Yes that's a great point. I think, you know, one of the trickiest things when we're thinking about the framework for measurement always comes down into, you know, we can think about what's important to measure and how we try and create a comprehensive framework that names what's important and starts to be the ultimate repository for all the ways in which we're going to measure preparedness. But then, you know, it always logically everyone asks well then, you know, who is measuring and who is holding us accountable and how far does anyone's scope of responsibility go.

And this comes back a little bit to that supply chain comment of, you know, can you really hold a hospital responsible for ensuring that, you know, every one of their suppliers has excellent business continuity practices and that they will be able to access supplies. So I think to your point about, you know, how deep into the community does an individual health care system or healthcare providers responsibility go I think is an important one we're going to have to continue to wrestle with. So I think that was a very, very good comment. (Colin)?

(Colin): Yes, thank you. So a couple of comments sort of going into inventory levels and my concern there is a few years ago we did an assessment for the availability of some pharmaceuticals and found that pretty much every

hospital had an agreement with their distributor whether it was McKesson or whoever that they were going give priority service and resupply during the disaster. And it seems like the regional distributors or wholesalers are signing agreements willy-nilly with anyone that will let them sign it too, whether they're getting preferential payment or not. But that would be a concern with inventory levels as everyone is modified to just in time theory is counting on stuff that's not going to be there when they need it because it's going to be a mad dash for a small inventory since, you know, distributors are using just in time inventory.

Dr. (Paul Binninger): Yes, thank you. Yes that's also, so obviously incredibly important point. You know, you don't, it does almost beg the question of who is watching, you know, at a higher level to try and see how many of these kinds of agreements exist and what is practical or not. But I don't know whether that, you know, could be accommodated with in this framework. Yes, a really, really good comment.

If I can if I might want to transition I think the slide is already up for measure concepts. And hopefully everybody still has the email from yesterday that had the measure comments listed in the Word document for them. As you can see if you go to Page 2 for the measure concepts currently listed as stuff still as a header, they're divided currently into the four emergency management phases and there are six well I guess five different measure concepts listed under stuff.

One is about par levels. This gets obviously gets back to the inventory question for PPE and medications. Secondly is availability of critical supplies that are non-pharmaceuticals. During response availability of critical pharmaceuticals and then the mitigation phase talking about ability to purchase recommended disaster supplies or the having had purchased

recommended supplies. And then there was mitigation measure concept was this idea of a frequency that you on a recurring basis review your consumable supplies make sure that they have appropriate expiration dates and, you know, the inventory is verified annually.

Could I ask folks to comment on this? I think, you know, as with the other domains I don't think we think that those measure concepts are comprehensive yet and really would welcome more input and more suggestions from all of you on adding to these measure concepts. But can I ask if they are appropriate or are there ones there that don't belong or that you'd like to have removed you certainly I think for all of these they're going to need some tweak on the wording but can I ask for some input and feedback on the measure concepts as they're listed currently within that Word document? And just as a reminder if you can raise your hands it'll make it easy to call on folks.

(Jesse): And this is (Jesse). Also what we're looking for, you know, particularly if there are areas where there are no measure concepts. So in this section, you know, if, you know, under specifically, you know, looking sort of across the document under supplies you don't have any ones for recovery, you know, so just sort of thinking about whether or not there are, you know, once we could fill in or other ideas?

Dr. (Paul Binninger): Great thanks (Jesse). (Stacy), if you can go, and then (Mark) and (Caitlin) after.

(Stacy Cokerum): Sure, hi (Paul). So I had comments on the recovery measure. So I was trying to think through like what at this point what in recovery you need to be thinking about. And so what comes to mind is me thinking about having some capacity or process developed for you to actually be able to take inventory and

even determine what you, what type of supplies and resources you'd need to actually recover because there, you know, you can do planning ahead of time. But there's always that sort of just in time assessment that you need to be able to determine how to put together a recovery plan your sort of post incident post disaster recovery plan.

So I would say so there could be something around that for recovery sort of that process for how to assess what inventory and supplies you need because that will be different from your response. Certainly your response you're just looking at what those critical supplies are whereas you're starting to think about restoration of services that may not be as critical or the restoration of facilities if you're looking at the recovery phase. So I would see some sort of assessment or process for recovering and recouping some of those additional services and supplies happening at that point.

Dr. (Paul Binninger): Yes I like that. Thank (Stacy). Can I ask you a follow-up? Do you think it's appropriate to consider a measure concept around coordination of recovery with respect to supplies? And what I'm thinking of is in, you know, 2009 you may remember we're here in the Boston area had, you know, everybody was running short on M95s but some folks actually ran out. And in the recoveries people were trying to replenish stocks and bring services online just having everybody order back to par levels, you know, disadvantaged certain folks. And ideally some relatively thoughtful coordination around the community can allow those with more not to try and order and replenish their stocks faster than those who had none. Does that make sense or not because I know you are obviously involved in that.

(Stacy Cokerum): Yes, no it definitely makes sense. I mean I think part of what I'm still trying to reconcile is we're going through this process and talking about all of these measures is actually what I think folks keep coming back to about who is

actually being measured? Who is it that is responsible for meeting these concepts and actually being measured to determine whether or not we've been, or we're ready? And so I think it's kind of a delicate balance of what's the actual measure that's being put upon a facility versus if we actually are looking at a true health care system readiness.

Is there room in this process in this work that we're doing to have measurement concepts for coalitions for example, or for (ESS8) leads or some of those other response, or some of those other entities that are responsible for health, part of the healthcare system that aren't that are necessarily a facility based agency? And again it's because I'm, you know, I'm thinking as we're going through this I'm thinking that a lot of what we've been talking about is still facility based. So when you think about healthcare system it's not just the sum of individual readiness of the individual facilities you do have to, we do have to work in some way to measure that larger system outside of a facility and, but make sure at the same time that we're not holding facilities accountable for meeting those numbers?

Dr. (Paul Binninger): Yes so something that's really, really important and, you know, (Jesse) or the other NQF staff may have comments on this but, you know, it's probably important to stop here and just remember that, you know, what we're working on is a framework a comprehensive look at what we would want to measure for the readiness of the healthcare system but it does not automatically mean that every measure applies to every level or every entity within a system. And that likely actually, you know, the question of who is being measured for different measure concepts or the actual measures themselves that they're being applied to different folks depending on what's appropriate for their scope of authority and responsibility. And so just because something is included as a measure or as a measure concept does not necessarily mean I think that it's being applied to every actor within a healthcare system. It's

again any, you know, (Jesse), or (May), or (Punim) do you have any, you now, thoughts on that?

(Justin): Yes so that's a great point (Paul). So typically when, you know, you specify a quality measure that there would be, you know, specifically a setting where that measure would be most appropriate. So, you know, you have these, you know, non-readiness measures. You have measures that apply to inpatient settings, measure that apply to outpatient settings, you know, measures that apply to nursing homes. I mean there's a variety of measures that can be designed and in the measure specifications you're going to have which specific setting is measured.

I think one of the things that differentiates this topic from some of the others particularly in readiness is that the, you know, in order to, you know, improve your, you know, central line related, you know, bloodstream infections rate that's usually something the hospital is doing by themselves. But, you know, really for a community and/or, you know, healthcare systems as we're defining it being ready it really does involve, you know, the broader participation in, you know, in the community. So, you know, I think another way to sort of a level of measurement is, you know, a measure that would impact, you know, a number of different settings and (unintelligible) that they would, you know, basically hold, you know, hold everyone accountable for readiness or for disaster response.

Dr. (Paul Binninger): Awesome, thanks so much (Justin). (Punim) or (May) anything otherwise we'll move on to (Mark)?

(Punim): Before we jump to (Mark) nothing to add on to that point but I did want to bring up that (Jay Taylor) did put some comments into the chat box mainly just around ideas for measure context. For response he said availability is

transportation EMS, wheelchair service, bus and then for preparedness care sites identified. I think some of those might be more of the alternative care (unintelligible) may be more relevant to our structure section so I did want to make sure to bring up his points.

Dr. (Paul Binninger): Awesome. Yes and I do think to (Jay)'s point about transportation, you know, some of those things really are stuff kind of questions. You know, do we have, you know, large (unintelligible) buses, do we have sufficient wheelchair vans are ambulances? So yes so really good comments. And I also see think you (Punim) for pointing that out. (Nicolette) and (Stephen) have just joined as well for everybody's awareness. (Mark)?

(Mark Jay): Yes just a quick comment not to, you know, to carry on about this. But I think that one of the things you may want to think about is not only as a metric (unintelligible) purchasing but, you know, and it gets back to the recovery but even just during an event and MOUs to share supplies. That really, you know, that should be established in advance so that, you know, you can get from other facilities or other communities either that are surrounding you to be able to get it. But an MOU with other facilities should be I think part of the supply issue. And the other issue would be having a process to appropriately reuse one time only devices, or equipment, or supplies which in an emergency you may have to, you know, do because you can't get resupplied but have a mechanism to be able to address that safely.

Dr. (Paul Binninger): Excellent great, both great points. Thank you. (Caitlin).

(Caitlin Durvey): Yes. So I was just kind of listening to the discussion I think this was great. And one of the things I think related to specifically the discussion about is it the healthcare system versus the supplier and who is being held accountable. Obviously now with drug shortages we can't hold the facilities accountable

for drug shortages. But what most people are looking at for a readiness for drug shortages is really do you have a process in place? So I think in the aspect of measurable concepts it's do these facilities have plans in place to for response and recovery resupply? Do they have a plan in place as to how they will contact and who they will contact and if they have a backup contact. So I think it's more the measuring that they have plans in place and then that they test them.

One of the things we do, we do this a lot because every year we replan for hurricane season. So we actually are testing those things and planning for them and readjusting our list obviously knowing that in a shortage a medication might not be available but we know what our list is and then when those things happen we can make changes. So I think for all of these category with supplies and other needs I think that would be kind of measurable concept that there's a plan in place and there's backups. And I do agree with the last comment about creating plans or contracts to share amongst resources. We obviously don't want people just like after Ebola to be mass hording supplies just for being prepared so recognizing that the concept of every one working together to handle a situation when it occurs is also an important part of this.

Dr. (Paul Binninger): Yes excellent, very, good. Thank you. (June)?

(June Kale): Yes, on that point, on the for prepared measure I don't have, the laser language you're probably looking for but this comes up in many settings beyond health systems at least in my work and that is the contracts. Even the testing good but before testing the clarity of expectation of delivery of the supplies and the specificity of expectations that is the language in the (unintelligible) of delivery and also that these contacts when possible they go three deep. So the backups the specificity of the backup is there is more than

one contract for a supply and it (unintelligible) through geographic location as well if two contractors are totally taken off-line there is a third. So I know it's really granular but I see it not getting attended to. And sometimes it's very important they have that kind of specificity of backup and specificity of contract language.

Dr. (Paul Binninger): Excellent. Yes, no a very important point. Thank you very much, (Glenn) and then (Angela).

(Glenn May): Hi. Yes this is (Glenn). Just to echo a few thoughts around some of these measurement concepts. I might suggest thinking about how to incorporate the concept of supply distribution a little more deliberately into the measurement concept and it relates to some of the issues that have already been raised around are there plans in place for system level, you know, sharing of resources thinking about that from a distribution perspective.

And also potentially thinking about whether there - having plans in place for supporting, you know, sharing of supplies across the system. We might also think about measuring the availability of information systems that can enable facilities that assist and allow you to share information about their supply levels and to empower them to make informed decisions about how to best distribute those during response as well as recovery strategies.

That also (unintelligible) that we could also potentially think about in this domain as well thinking about distribution level strategies around the strategic national stockpile of supplies. And there are exercises and drills that are conducted around again distribution strategies around strategic national stockpiles. So that may be, that may create some opportunities for some measurement. And then finally I think this has come up in some of our earlier discussions but we may also want to think about supplies that are, that exist

and are used in the home. And so before that, you know, make certain households electricity dependent and think about some extending measurement concepts to addressing supply needs that are in the home.

Dr. (Paul Binninger): Excellent yes. All great points and, you know, definitely I think that the scope of making sure that persons, patients who have medical needs, medical supply needs at home are included within the framework is really important. So that was (unintelligible). (Angela)?

(Angela Hewitt): So I just wanted to bring up real quickly, you know, I think that the recovery process is actually an excellent time for sort of a after action evaluation of supplies not only just the raw number of supplies but also the functionality of those. I know when we were taking care of Ebola patients here on campus in 2014 we, during the recovery process was really when we took a really hard look at our protective equipment not only how much, you know, did we actually need but the real kind of raw functionality of that. And whether we needed to reassess, you know, the type of equipment we were using and not just with PPE but with also medical supplies and the feasibility of (unintelligible) and these supplies and that sort of thing.

So I think that the recovery process is really that time when you can actually take a hard look at those, you know, at those supplies and like I said not just sheer number but also just the functionality of those. Thanks.

Dr. (Paul Binninger): Yes, I think that's great. You know, if I can sort of carry forward a comment that was made yesterday into this discussion and kind of, and merge it with your comment (Angela) that outcomes I think are so incredibly important right? That trying to look and say, you know, did we have enough of what we needed when we're in that recovery phase? And to your point, you

know, did what we have work? Did it was it what we needed not just did we have enough of it or did we have access to it?

And both in exercises and then when there have been real events I think taking that moment of step back and making sure that health system readiness takes into account a structured look every single time at the outcomes of what we planned for, what we had, what we used is extremely important. So I think that was a great comment. (Scott)?

(Scott Anderson): Hey and I apologize if I disappeared for about ten minutes and there. So if I say something over again apologies in advance (Paul). So mutual aid plans to have that in place between nonaffiliated providers and for sharing of supplies so that has been a successful model across multiple states and the importance in that will be the advanced knowledge of what each institution can handle when the suppliers are unable to respond.

Dr. (Paul Binninger): Yes, thanks (Scott). We, you know, we touched on the concept of MOUs for resource sharing but I think we didn't as much talk about, you know, inventory awareness and, you know, capabilities when supply chains are interrupted which I think are related concepts you're bringing up that are also really important. I know that was great.

(Scott Anderson): But the MOU will be obviously a piece to that and then the mutual aid will support that with knowledge (unintelligible), great thank you.

Dr. (Paul Binninger): Yes, no exactly. I think that would be perfect, very, very helpful. Good so we are, there aren't further hands raised right now and we've gone through the measure concepts. You see, you all see the questions on the slide here in front of us. And then the only other question that we have in addition is whether

you all are aware of existing measures that are appropriate within this framework for supplies.

So again, you know, with the framework the way we're considering it we do not want to be limited only to measures that currently exist. I think as lots of folks know we don't yet still have an existing comprehensive set of measures that touch on everything for, but looking at framework, you know, it measures that we have, you know, obviously we have some very good existing systems that measure some things. Does anyone want to suggest currently any measures that they're aware of or certainly if I may I request as you think about this if you think about measures or want to suggest measures to the NQF team as you think about measuring supplies it would be great to just, you know, have you send everything that you'd like to suggest. (Margaret), any, oh sorry please there was another comment?

(Punim): I was going to add that while people think about anything they want to suggest I did want to just mention that (Steve) did put a common into the chat just saying disasters would have a tendency to deplete some or all supplies for the system at an institutional level. The recovery metrics would be a process which the health care system anticipates this and works within the local settings/system and beyond to address shortages that are the result of a disaster or public health emergency. I just wanted to make sure that comment was up to everyone and before we moved on.

Dr. (Paul Binninger): Yes thanks for (unintelligible). I'm not doing a good enough job of looking at those comments so thank you so much. (Margaret), did you have any other additional thoughts on the supplies and that otherwise I think we'll move onto the next domain?

(Margaret): No I think that you've covered it beautifully. And a lot of great ideas added to today so I'm glad we spent some time kind of circling back to this particular area, a lot of good information.

Dr. (Paul Binninger): Awesome. Yes and I would echo (Margaret)'s comment, you know, this discussion is great it's been great today it was certainly great yesterday. So I'm hoping as we head into the next domain we'll be able to continue this. The next domain is structure. And so, you know, this now is the space basically within which care is delivered. And just like we said with the previous domain staff and for stuff or supplies this is really meant to be quite an expansive interpretation of the term.

So certainly it would not only mean acute care hospital buildings but it means, you know, long-term care facilities, community health sites, urgent care centers, primary care, physician's offices. And to the community point I think, you know, individual people's homes to the extent that we want to anticipate and think about how healthcare systems can think about the integrity of that. But also I think we should be thinking about medical care within shelters, you know, those medical needs shelters or other sheltering sites where medical care needs to be provided probably I think all or relevant here.

So within the proposed subdomains that have been suggested so far we have the list here on the slide that you see. And there is one suggested example under the assessment of facility. I won't read the whole slide to everyone but these are the proposed subdomains of how we (unintelligible) whether the sites of care that we need to maintain in order to have resilience of our healthcare system in the face of disaster are, this is currently the list that we have. So if I can ask you to again start raising your hands and let us know, you know, what you think of these subdomains.

The questions which I'll move to in a second on the next slide but is, you know, are we missing any subdomains, are you okay with the wording of the current subdomain? If you want to think about them in the four-phased model prepare, response, recovery and mitigation I think that's all important. I just, I didn't want to take off the slide off the screen to quickly before we get to the questions and for those of you that do have the Acrobat file the PDF definitely please feel free to keep these open and think about them. But I'll move forward here and for our discussion if I can ask you to start raising your hands and let me know what you think about the structure subdomains.

(Punim): (Paul), do think it would be helpful for us to have the subdomains up instead of the question so people have a chance to…

Dr. (Paul Binninger): I think so. I'm especially visual so I would say yes. (Jay)?

(Jay Huron): Yes, the one thing that I'd say there that you might be missing in the recovery phase is actually returning patients to their facilities whether that's long-term hospitals if we move people to alternate care sites a lot of times having to get them back is probably an important part of the recovery process.

Dr. (Paul Binninger): Got it, thank for that. Other comments on the wording of some of these subdomains or the suggestions, you know, we had questions about say the word 100% previously. I don't know folks want to evaluate, or comment, or speak to some of the things like up to date, or day to day or how we look at that. And again I think, you know, we looked at ordinary function, functionality and capacity versus others. Let me see I think I hopefully got the order correct but (Suanne)?

(Suanne): Hi. Just in response to the last persons comment about returning patients to their home facilities would that be under timeliness of return function?

Dr. (Paul Binninger): I think it could be although often it's, you know, we what I think right now some of the main interpretation of that is returning the facility to its function. So, you know, yes maybe. I think like a couple of other things that have come up. It also may be about this may be a system issue about repatriation when the system is back up and functioning, you know, are we, do we have appropriate plans so that when the facility that was evacuated comes online it doesn't only look forward to new incoming patients but it looks to repatriate and readmit patience or, you know, others that were evacuated. So but I think that's obvious up to this whole group to suggest what you think the most appropriate interpretation of that is or changing of the wording. (Steve)? (Stephen), are you a mute by chance? Oh there you are. I hear you.

(Stephen): Can you guys hear me?

Dr. (Paul Binninger): Yes I hear you now.

(Stephen): Okay cool, great. Good afternoon. I was looking ahead to systems because I'm sort of trying to figure out where does structures and system intersect and there are probably lots of intersections. I mean I think advanced planning for alternate care delivery sites is important. And just to make a plea that really should be looked at throughout the entire health care system. So it's not just the, you know, the big clinics, or nursing homes, or hospital facilities but the primary care locations just because the maintenance of primary care during and after a disaster is kind of a key factor for the resilience of the entire health care system as well as the communities resilience.

And I'm not sure that there are probably communities where because they suffer through this so often that they've given this a lot of thought but certainly a lot of the pediatricians in Chicago haven't given it any thought as

an example or other primary care doctors. I presume facility evacuation plans is under systems perhaps as opposed to structure. And I guess the process by which a structure there's a process by which we ascertain the safety related to a particular structure is probably a consideration that needs to be in there in terms of how that's going to occur.

Dr. (Paul Binninger): Yes I think you're exactly right on evacuation probably living more under system. But your point if I interpret from exactly is, you know, the appropriateness of an alternate care site not just for medical care but for specific patient populations obviously I think pediatrics is the perfect example that, you know, you can't just put kids at any place and know that they're going to be safe. And so maybe, you know, adequacy of appropriate, you know, disaster structures whether they're structures into which you would evacuate, or provide shelter care, or provide alternate care making sure they're appropriate for the patient populations that would receive care in that site probably fits if that might, if that, if you think that sounds correct?

(Stephen): No I think you've hit it. And I guess the other rhetorical question that I asked for which I don't have a real answer is where do schools fit into this?

Dr. (Paul Binninger): So to the extent we try to keep, you know, the focus on sites of delivery of care I think if a school were to be an alternate care site then it would fit. And if it's how the schools fit within the overall community emergency management system maybe they would be excluded. But I think, you know, yes if they are becoming a site of either primary care, or surge care or, you know, or they're becoming many communities obviously use their schools as points of dispensing I think then it's relevant.

(Stephen): Yes plus school directions source of a fair amount of mental health counseling on a day to day basis. Anyway just a thought, it's a random thought.

Dr. (Paul Binninger): No, no it's a really good thought. (Scott) and then (Mark).

(Scott Anderson): Hi. So our infrastructure is really broken into a couple different areas. And we may want to consolidate that a little. But we've got up to date presence of critical infrastructure not totally sure what that means. And then we've got the redundant power and transmission. But if we look at what our failures, our water, HVC, power, and gases and sewer we may want to narrow it. A lot of times there's a focus on power. But some of the greatest failures that we've had out there is the inability to maintain the environment outside of power. So again the terminology may just need to be altered and as we talk about critical infrastructure maybe it's just the wording of the title but I just want to make sure that we capture that.

Dr. (Paul Binninger): Yes, no we, that was yes well said. Excellent thank you. (Mark)? (Mark), are you on mute by chance?

(Mark Jay): I'm sorry I was on mute, yes. So I agree because I was thinking the same thing about, you know, it goes beyond power. The other issue is, you know, sheltering of community members when for various reasons they come to the hospital and they can't travel to a school or something like that or we have no way of getting them. So I can think of when we evacuated after Sandy we had people from the community who were flooded out of their houses and had no place else to go and were cold and wet clearly cannot, they did not need to be on medical floors but you need sites for them to stay. Also as well you need places for staff to sleep. If you didn't evacuate at your hospital but staff has to stay for prolonged periods of time and, you know, they are rotating who is on staff and who's not. So I would say for nonmedical care delivery structural sites and support for that that needs to be considered.

Dr. (Paul Binninger): Yes, I like that appropriateness of space for other needs of space associated with the medical system and staff very, very good. (Marcy) and then (Lucy).

(Marcy): So I think I would like us to explicitly address accessibility of the, in this section under the subdomains I think to the point to the recent point about those who make come to hospitals the point about those needing transportation away from the current facility for many, many people it's going to be not returning to another facility or not being served in that facility but being served in an accessible facility, i.e., a community shelter with the support and services that they need or being returned the, having assistance to be returned to the community afterwards or having assistance to move on to some other location keeps them out of the medical system the key medical system. So not just, you know, folks who are in facilities previously or folks who are in facilities throughout but folks who may be admitted who then need to be returned to a non-institutional setting or folks who show up at those facilities who need assistance to not be there and to be an integrated assessable setting.

Dr. (Paul Binninger): Yes I very, that's really important. I, that's great, excellent. (Lucy)?

(Lucy Sabbath): Two things strike me as I'm listening to this discussion. One is we're talking about structure in terms of sort of historical structure. And I don't see anything in here up bout virtual care or telehealth. And this is not my area of expertise but I just want to sort of insert that into the discussion especially if you think about the sort of broader landscape of different kinds of events and when they'd be, you know, communicable disease where you don't want people coming into places. And so just a thought to plant the seed in those minds to think about, you know, should structure include virtual care and sort of telehealth services?

Dr. (Paul Binninger): Interesting yes.

Man: Good point.

Dr. (Paul Binninger): I don't know if others have thoughts on whether, you know, it is a structure in a virtual sense or at least at the system but it definitely has to be considered. You know, obviously everybody is aware that a lot of healthcare is changing in that way and certainly, you know, more recently disaster planning about telehealth has really been evolving a lot. So that was, yes that's important thank you. (Figelli).

(Figelli): Hi. Thank you. I had so many comments. I'll try to make them succinct because I really appreciate, you know, what a number of speakers have said. So maybe starting with as I look at this list one of the things that, you know, that occurs to me is we've got a number of different things going on when we think about structure and just in terms of organizing our thinking it might be helpful to really think about. We've got look we've got physical facilities as delivery sites, we've got location and access to those locations. We've got the idea of capacity. We've got the idea of redundancy. And those may sound like they're the same but I think that they're really distinct.

And if we can make those distinctions more clearly in the language and even in organizing the list I think it'll help us think of the components. Much of, you know, and I really appreciate a couple of the points that others have made about schools and about things like for example virtual care and telehealth both as alternatives but also because on the one hand that's how care is being delivered in a lot of communities. And on the other hand you have to include those in whatever sort of capacity assessment vulnerability assessment so that once the event has occurred there on your inventory of things that you really

need to look to for both for reinforcement and for current availability if that makes any sense. So I think there's a lot of, you know, grouping that we could do and specificity that we could bring to the language that might help their.

Dr. (Paul Binninger): I think that would be great. And I know, you know, we would really welcome everyone's input on that. I think, you know, from the perspective of trying to have a comprehensive framework to look at health, at resilience I think we really want to make sure that the wording, and the organization, and the grouping really does span everything that we're thinking about. So I think you're exactly right on the money with that comment.

To that end I wanted to sort of open it up to everybody. I won't only put (Angela) on the spot but, you know, is there a need for subdomains related to the facility's ability to accept unique hazards? So I'm thinking of airborne isolation for, you know, a potential future outbreak of airborne and transmissible disease, or otherwise isolation capability, or, you know, not that certain every facility needs this but, you know, biocontainment, bio care capability, or hazmat decontamination capability for arrival within certain facilities or screening, you know, does the facility permit appropriate security barriers in terms of the structure depending on what it is. Does anybody have thoughts on some of these more specialty hazard scenarios as they all apply to structure and how we should be assessing resilience of the healthcare system from that perspective? (Angela), thank you.

(Angela Hewitt): Yes. So I agree with everything you just said. I mean I think the screening is particularly important. And I think that's something that we've seen across the healthcare system after the 2014 Ebola outbreak is, you know, are facilities prepared to screen patients for the most part. And would you actually recognize a person that came with an appropriate travel history and appropriate entomology? And then after that then would you be able to

isolate. And then would you be able to inform the appropriate individuals, you know, about the presence of this person your concern for, you know, that disease.

And so I, yes I mean I wholeheartedly agree with that. I think that having every healthcare system and I'm speaking particularly from, you know, from the preparedness for infectious diseases obviously but I think that every healthcare system needs to have a plan in place on, you know, number one what are your capabilities. You know, is it, is your capability to be able to identify and then isolate a person but not necessarily to provide long-term care for that individual. And you would need to transfer to another facility and that sort of thing or is it your capability to actually be able to provide that sort of care for patients with, you know, highly infectious diseases whether those are, you know, are airborne or contact transmissible, et cetera. So again I think having those plans in place of what your facility is capable of and this extends not only to acute care facilities obviously but clinics, and long-term care, and, you know, lots of other facilities as well. Thank you.

Dr. (Paul Binninger): Yes, no thank you. I think, you know, and obviously I'm showing my hand a little bit. I think it's important and I think one of the questions is how much is it subdomain unto itself that we look at the structures appropriateness for, or how the structures are evaluated for a typical hazards or rare threats. But whether it's more also just a measured concept that people have assessed the ability of their facility to facilitate appropriate screening or facilitate appropriate isolation or to support appropriate decontamination of contaminated patients as they arrive. And so I definitely would welcome people thoughts on whether you think it's more of a subdomain or whether it's really a measured concept.

While you're mulling I may go ahead and move us forward a little bit from this list to talk about the measure concepts which is right sorry there. That, you know, you all, you still have the Word document with the measure concepts on it and there are many that are listed here, listed on that Word document for the structure and measure concepts. And if I can ask you to comment on that or if you have remaining comments on the subdomains please feel free as well. But are the measure concepts as listed are they appropriate, are they in the right phase of emergency management response, or the emergency management cycle excuse me? Thoughts on the measure concepts are they appropriately scalable and generalizable?

You know, we again need to make sure we think about some specialty hazards as we were just talking about between infectious disease outbreaks, or mass casualty events, or security events or hazmat events but we also of course need to have a comprehensive all hazards approach, any thoughts? I'm not seeing any hands right now. I don't know (Margaret) if you have additional comments or (Punim) maybe (Jesse) if you have additional thoughts?

(Margaret): Yes, this is (Margaret). I just wanted to make sure the folks that do have the Word document that they have access to those measure concepts to be able to look through the four different phases. And we welcome your comments on what's currently there and any additions you think need to be added to the list or things that can certainly be removed or are up for a discussion.

(Jesse): And this is (Jesse) here just to respond to what (Colin) said. You know, I think that overall we are taking like I said before an all hazards approach but including structures that are more specific I think would be valuable. Now some of that may exist within a regulatory framework but, you know, if there are things that, you know, very specific structures that, you know, would be necessary, you know, during certain types of, you know, certain types of

responses and you mentioned maybe special rooms and things like that I think that would be appropriate.

Dr. (Paul Binninger): (Stephen)?

(Stephen): Yes hi. Can you guys hear me?

Dr. (Paul Binninger): Yes, thank you.

(Stephen): Again I was just looking at the various measures. Again from a recovery measure concept since it's, I mean part of this is we're focusing largely on the ability of these various domains this point structure to rev up to what's necessary to meet what's necessary as dictated by the event. In theory of events eventually stop or they diminish to the point where your, you then need to go back to standard operating processes. And you might repurpose things back to what they were originally used for. But, you know, like an endoscopy lab that's being used for something else during the disaster as an example. And so, and the healthcare system needs to when it's appropriate to do so it needs to have a mechanism in a reasonable efficiency to sort of go from disaster mode to normal operations mode. So, you know, something along those lines would be a good recovery measure concept.

Dr. (Paul Binninger): I like that. I think certainly, you know, the measure concepts are the ability of the, you know, can include definitely the ability of the structure to return to normal operations, you know, at an appropriate plans or in place to return facilities to normal operations. Yes they're really good ideas. (Caitlin)?

(Caitlin Durvey): Can you hear me?

Dr. (Paul Binninger): Yes, thank you.

(Caitlin Durvey): Okay. Yes along the same line I think just the assessment of the facility whether the structures or things are still usable in addition might be a good one for the recovery concept.

Dr. (Paul Binninger): Yes, I like that from easier to recover faster if you have a plan for what data you need and how you go about getting it to make sure that the facility is appropriate for reuse. (Marcy)?

(Marcy): This is (Marcy). And that always need to include accessibility.

Dr. (Paul Binninger): Yes. Yes, thank you, absolutely. I think pre, during and post the accessibility assessments (unintelligible).

(Marcy): Yes, this is (Marcy). And unless it's explicit, you know, you know what they say it's implied it's not applied. So, you know, I think we need to overachieve in the language. So thanks.

Dr. (Paul Binninger): Yes, no agree with that. Definitely agree with that. Okay any other comments on either the subdomains of the measure concepts? (Barbara)?

(Barbara Cicerella): Yes I had to unmute. Thanks (Paul). I'm looking at the structure and as I'm listening to this conversation and I think there are some of those on the line that are really most concerned about the people out in the community that are either in a system such as a health care, hospice, other types of support services. And so what I'm looking at the structure for me -- and I would welcome comments from the rest of the team -- what I'm not seeing here is any type of measurement that ensures a collaborative effort between the system and the component. So I put that out there for discussion.

Dr. (Paul Binninger): Yes I think that is a great point. Can I ask you to just say a little bit more about this that, you know, we have the boundary of facilities that deliver care. And so certainly there is a lot of important I think burden and responsibility for emergency management agencies, and governments and others. But I think there's still potentially a role to some degree for, you know, health care delivery entities. And I just, can you expand on that because I think that's an important point you're raising?

(Barbara Cicerella): Yes we have pace programs, we have home care agencies, we have hospice, we have palliative care, we have people that may be patients by physicians but not necessarily linked up to a particular system. There are still some independent physician practitioners that are out there. And so when I'm looking at the structure component we still have silos in spite of the fact that we have healthcare coalitions many of the 17 providers that are listed in the regulation are still not players at the table.

So if we're looking for an entire system to be ready, the entire health care system of a community to be ready, I think one of the measurements would have to be the effort of collaboration with the entire health care system. And I don't see that. And when I'm listening to the conversation I think there are many of us that are probably questioning we know the hospitals are going to do well basically because they've had a lot of practice but not everybody has practiced.

So an example would be Ebola. While we think of Ebola as being primarily a facility-based problem when you get into community based care many of those healthcare providers at the paraprofessional level are transient workers and go back to example to Libya or to other parts of Africa where we've had outbreaks and stay there for months to visit their relatives then come back to the United States and come back doing work in the community. So I think we

need to look at how we're going to ensure that the system is in fact the system and not the same usual players. That's (unintelligible).

Dr. (Paul Binninger): Yes and if I may be if I offer up a question in terms of, you know, from a structure standpoint if the health care system whether it's as you said hospice providers, or, you know, visiting nurses, or providers of care that oxygen dependent, or mechanically dependent, or power dependent patients at home if we've started to look at as a measure concept how the healthcare providers for those patients help them assess the adequacy, or resilience or help them improve the resilience of the place in which they live or if they're being evacuated to a shelter how to help improve and how to assess the adequacy of that medical shelter to provide for their care needs, accessibility, certainly (unintelligible) just came up. Does that make sense? Is that an appropriate way in which the healthcare system can improve the resilience of the structure to provide care for patients who are out of the healthcare system but definitely have needs? Does that make sense or is there a different way to think about that?

(Barbara Cicerella): I think that's part of it. I think the big piece for me is again the prevention of silos and making sure that all the players are talking to each other and are part of the community readiness. So many times as I'm going around working with healthcare coalitions and we're doing exercises there is no home care. There is no hospice. There is no case program. You know, not all the players are always at the table. So, and I think that should be an outcome measurement I guess is what I'm really saying (Paul) is it should be an outcome measurement of how a system will be ready.

(Jesse): And this is (Jesse), if I could comment on that. So if you go back down to under system I think you're going to see at least under those some of those concepts are there with participation, and health care coalition, transfer

agreements and community assessment. So I think you're going to see some of those in the next section. But I, you know, I do 100% agree that, you know, creating ways to measure, you know, the actual delivery at the community level is what we want.

You know, the and specifically, you know, how do we sort of take all the health care entities in a community and make them accountable for how the whole system behaves in a disaster. So, you know, so for example let's say, you know, taking something like, you know, stroke care making sure that the, you know, that the patients are getting the right stroke care, you know, not only sort of within a single hospital but sort of taking that level of measurement at the community level, you know, seemed an example of, you know, creating an incentive for one for, you know, more cooperation among the entities. And then two for just sort of taking, you know, taking responsibility for the broader, you know, community beyond the four walls of an institution.

(Barbara Cicerella): Yes. And that's essentially what I'm talking about because the reality is if we don't look at the community providers and make sure that they are a collaborative partner in this process their patients are going to be the ones that show up at the ER in the hospital with that secondary surge.

Dr. (Paul Binninger): Yes. Thank you so much (Barbara). I think, you know, let's definitely make sure also in addition to including, you know, those comments here when we get to the next section on structure it's going to be as I think (Jesse) said really, really important we keep, you know, make sure that we include that appropriately in that part of the discussion as well.

(Barbara Cicerella): Thanks (Paul), I appreciate that.

Dr. (Paul Binninger): Yes absolutely. (Mark)?

(Mark Jay): Yes, no I mean I am certainly in agreement that, you know, we cannot have silos. And I agree with the statement that if we don't include these people that these are the people that are going to overwhelm our EDs in a situation. However I think we have to be careful in terms of metrics. Much like many of the metrics that CMS makes us do there are areas where the hospitals can have influence and there are areas where the hospitals have control.

And I think we have to be careful how we parse the metrics so that it doesn't make it look like the hospitals have control over those situations because sometimes both by regulatory other issues can come into play that make it difficult. So using a coalition model that's inclusive and saying, you know, do you participate in a coalition that has the following membership or, you know, categories or whatever may be one way to do it. But without, with recognizing that beyond that the hospitals have no, you know, they can tell a voluntary position or a person who was out in the community this is what you're going to do and this is what you have to have in your office they can only influence they can't control.

Dr. (Paul Binninger): Yes. I totally agree with that (Mark), absolutely. Excellent are there any additional thoughts on structure on the measurement concepts, on the subdomains too? And I see your hand is raised.

(June Kale): Yes (June) (unintelligible). Just to, and again maybe this is the best discussion but I think the measurement in terms of the collaborative effort there's some regulatory limitations that I think the health systems have a reflex response in terms of the collaborative effort. And that is well we have the health care coalition therefore we are okay. And that leaves out many of the critical community players.

So if that's part of the regulatory definition of, you know, the CMS 17 entities sometimes you just get left out. The health plans aren't part of the 17 entities in living centers, area agencies on aging, developmental disability centers and other disability related service organizations. I know you can't force but even the invitations don't get extended because we as I'm thinking that we've met our collaborative community obligation because we have a health care coalition.

Dr. (Paul Binninger): Excellent. Thank you…

(June Kale): I'm just trying to get that on the record so we're not limited by that.

Dr. (Paul Binninger): Yes, no. And I think if I may I'm going to have I'll carry, I think we should carry that comment forward into systems as well. It's important here but I think, you know, I think when we get into the system subdomains I think the point of trying to make sure that there is an actual inclusive system that takes all vulnerable populations into account and that the agencies, and providers and representatives that know these populations best and can advocate and can provide resources are all appropriately part of the healthcare delivery system and contribute to healthcare resilience is going to be really important. That it's more than I think someone had said before but, you know, more than lip service, more than a checkbox it is important. So your comment, (Barbara)'s comment others have been I think really very helpful in that way.

So I guess what I would say we've gone through the measure concepts. We should ask, you know, are there any existing measures with respect to structure that people feel we, you definitely want us to include within the framework? Pause and see if anybody wants to include any of those now. And then if we, if after we have this discussion I will ask that the of the, of the

NQF staff whether you're going to want us to go ahead and move into the domain of systems or whether we should take it all as one bite in tomorrow's call we will obviously defer to your judgment on that. But before we head into that any comments on specific measures or (Margaret) did you have anything else you wanted to add or highlight?

(Margaret): No, not for structure. I think we've covered a lot of things today that kind of have overlapping into systems. So I am very interested to see how those discussions will kind of lead us into the systems discussion. So from the NQF's perspective do you have a preference of whether we should kind of end for the day, wrap up for the day and really take on structure for the entire time tomorrow?

(Punim): You know, we still have about 20 minutes. I would say let's at least introduce systems and then we can continue the conversation after that. Do you prefer that we do public commenting now or just do it once we're kind of done with introducing system?

(Margaret): I think that's your call.

(Punim): Okay. Why do we go ahead and do commenting. And then we can at least introduce the system portion and then continue the conversation tomorrow. Sound fair?

(Margaret): Sure.

Dr. (Paul Binninger): Sounds great.

(Margaret): Is that okay with you (Paul)? Okay.

Dr. (Paul Binninger): Yes, yes, yes.

(Punim): Okay we're going to unmute all lines.

Operator: The conference has been unmuted.

(Punim): Would anyone, a member of the public like to make a comment on any of the discussions today? Okay not seeing any. (Paul) or (Margaret) did you want to talk through the domains or did you want me to go through them?

Dr. (Paul Binninger): I don't feel strongly. (Margaret) what's your preference?

(Margaret): I really don't have one. I am comfortable either way.

(Punim): All right.

Dr. (Paul Binninger): Well (Punim) why don't you lead us off and then we'll dive in.

(Punim): Okay perfect. So for systems we have a couple, more than a couple, subdomains listed here. First is community assessment, then the evaluation and response plan. We got communication plans, cooperative agreements, policies, external and internal, staff survey tool for after action evaluation and emergency communication and warning systems. And this is within the (health) system.

We also have testing of functional and full scale exercises. Again the sub bullets underneath each one of these are just examples to help you understand what could fall underneath each one of these categories. But otherwise that's the subdomains that came out of the assignment that everyone did. So with

that (unintelligible), sorry go ahead. Did someone want to make a comment? I thought I heard someone.

Okay so I know we have about 20 minutes left. I just wanted to do a quick introduction of that. We can continue this discussion tomorrow and really have it focus on the systems part. Please, you know, look at these subdomains and see if you think are missing and that doesn't seem appropriate and so on. And then also thoroughly look through the measure concept list to see if have measure concepts…

((Crosstalk))

(Punim): I'm sorry.

((Crosstalk))

Dr. (Paul Binninger): I think somebody might be on, off mute that thinks that they're on mute.

(Punim): Oh, okay. Let's go ahead and just mute everyone (unintelligible).

Operator: The conference has been muted.

(Punim): Thank you. So yes we will continue tomorrow. We'll give you back 20 minutes, you know, back on your Thursday. We have one more meeting tomorrow to go through systems. I have to say I am quite excited about how much progress we're making. These conversations have been wonderful and they're really helping us at NQF pinpoint exactly what needs to be done next. And it's great that we're able to get through so much. So hopefully starting tomorrow we can get through systems and we can go from there and let you know next steps after that. (Nadia) do you mind unmuting everyone?

Operator: The conference has been unmuted.

(Punim): Were there any questions before we let you go?

Woman: Thanks everybody.

Man: Thanks so much everybody.

Man: Thanks everyone.

Man: Thank you everyone.

END