

CENTERS FOR MEDICARE AND MEDICAID SERVICES

Special Open Door Forum:

Public Health & Medical Preparedness -- HSPD-21, Paragraph 40

Enhancing Healthcare Provider Preparedness

Moderator: Natalie Highsmith

March 14, 2008

1:00 pm ET

Operator: Good afternoon. My name is (Lori) and I will be your conference facilitator today.

At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Special Open Door Forum on Public Health and Medical Preparedness HSPD 21 Paragraph 40 Enhancing Healthcare Provider Preparedness.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you would like to ask a question, please signal by pressing star and the number 1 on your telephone keypad. If you would like to withdraw your question, press the pound key.

At this time, I will turn the conference over to Natalie Highsmith. Please go ahead, ma'am.

Natalie Highsmith: Thank you, (Lori), and good morning or good afternoon and thank you for joining us for this Special Open Door Forum on Public Health and Medical Preparedness.

This Special Open Door is being held to discuss ideas and suggestions from you for implementing Paragraph 40 from Homeland Security Presidential Directive 21, Public Health and Medical Preparedness.

Paragraph 40 describes criteria for implementing such a plan, that it relies on current grant funding programs, CMS requirements, and other identified means as not to increase healthcare costs.

This ODF will be used to share ideas that may enhance ways for the federal government to facilitate private sector healthcare facility preparedness without increasing healthcare costs.

The purpose of this Open Door is not to debate the merits of specific policies, procedures, requirements, or proposals.

During this Open Door, staff will provide an overview of HSPD 21, Paragraph 40, describe how input has been received to date, and moderate brief presentations from Open Door participants and explain the next steps in the process.

There was an email notice sent out yesterday afternoon with the link to the Open Door Forum - Special Open Door Forum page for you to review the

downloads for today's call. That web link is
www.cms.hhs.gov/opendoorforums with an S.

You'll see the Special Open Door Forum link on the left. Once you click on that, you can go down to the download section and you will see seven links for today's Open Door.

The first link is just the announcement. The second link is the agenda. And the third through the seventh link are the various materials, background materials that we would be discussing today.

The chairs for this call, we have two chief - deputy chief medical officers from the National Disaster Medical System. And that is Dr. Timothy Davis and Dr. (Dennis Fitzgerald).

We have two CMS staff here, Ms. Peggy Sparr, who is a deputy director of the Louisiana healthcare rebuilding staff, and Susan Larsen, who from our Survey and Certification Emergency Preparedness (unintelligible).

I will now turn the call over to Dr. Timothy Davis for his remarks.

Dr. Davis?

Timothy Davis: Good afternoon. I am Tim Davis. I'm a commander with the United States Public Health Service and I'm one of the deputy chief medical officers with NDMS. And we're part of ASPR, the Assistant Secretary for Preparedness and Response within HHS.

To the point, we are facilitating this Open Door Forum on HSPD 21, the Homeland Security Presidential Directive 21, Public Health and Medical

Preparedness that deals with preparedness and response to either a sudden onset violent mass casualty event or a slower onset mass illness event.

We will focus today just on a - one or two aspects of HSPD 21, primarily that contained in Paragraph 40, the financial incentives and limits, although we will be segueing into - we anticipate at times into topics related in Paragraph 30, which are the legal and regulatory limits and restraints because these do impact the financial limits and incentives.

This is - again emphasize this is to deal with mass casualties or mass illness, not any other aspects of difficulty we have with various medical issues.

Dr. (Fitzgerald)'s efforts have focused on the legal and regulatory impediments to mass casualty care in Paragraph 30. Ms. Peggy Sparr and I have concentrated on identifying proven - concentrated on identifying proven, proposed, hypothesized, or conjectured ideas, off the wall as they may seem, to identify any cost or budget-neutral financial solutions, incentives, or impediments for healthcare facilities to prepare and respond to a sudden mass casualty surge or a more sustained mass illness epidemic.

Anything and everything is on the table, all the better if it's evidence-based or already piloted, but there are absolutely no rules, boundaries, or limits to any proposal we're willing to listen to.

I would prefer that any problem identification be held or quickly segued into your idea or solution. We're hoping to limit each caller to two minutes so that we can get as many callers in as possible.

If you have additional information or you are not able to get your idea in, we ask that you use the email that's posted and that's hspd21-40_ndms@hhs.gov. We'll repeat that email link a couple times during the session.

Today we are here to listen. We are here to gather ideas and not to comment, judge, weigh, or scale. Again, all bets are off in terms of what is reasonable or unreasonable. We're here to get ideas. We will ask questions only to clarify. We will comment only to hopefully stimulate and move the conversation along.

Callers that can't get in during the time limited again are encouraged to use the email link so that everybody can get all of the ideas we have available.

The process that we will go to after this meeting is over is a transcript of today's Open Door Forum will be studied by a panel of the federal partners and ideas will be categorized and used to prepare for one or more focus groups.

Regardless, the transcript of this session and your - with your ideas and suggestions will be part of any final product developed for the White House.

Now I'll turn it over to Ms. Sparr.

Peggy Sparr: Welcome, everyone. I'm Peggy Sparr and I'm with CMS's Office of the Administrator currently working on issues relating to the rebuilding of the Gulf Coast states.

Thank you for arranging your busy schedules. And thanks, Tim. I think you've laid out a challenge to us, especially because the directive lays out specific

criteria that there can be no extra cost as part of the proposal to the healthcare system.

Disasters like blizzards, tornadoes, wildfires, even hurricanes, are not a new phenomena. Though CMS's programs are specifically not designed as disaster programs per se, CMS has always used whatever flexibilities we have within our current arsenal of authorities to try and meet the needs of local communities during the time of a disaster.

Our experiences with responding to 9/11 and Hurricane Katrina added a new dimension to CMS's role in administering Medicare and Medicaid during disasters of a different proportion.

Even though these were not mass casualty events, the complexities brought about by the sheer size, the migration of the population, the breakdown of law and order in some cases, all caused us to expand our need to exercise flexibility such that we invoked our further authority to respond by way of a Section 1135 waiver.

These are very powerful authorities allowed by Section 1135 that are limited, in fact, to those types of disasters that are declared public health emergencies that are declared by the Secretary under the Public Health Service Act and they are limited to the time that those authorities are, in fact, in place.

A high level summary of the requirements and flexibilities that CMS were able to consider during Katrina are identified as part of the materials that are available on the ODF web site. We do note that definitive descriptions of our actions.

If you need to have those, those are actually included in official documents, the Q&As that are posted on CMS's web site that will be discussed by Sue in a moment.

We'd like to know today what other requirements, what other policies, what other flexibilities need to be considered to deal with a mass casualty event or a mass casualty illness.

I'm going to ask Susan Larsen from our Survey and Certification Group in CMS to give a very brief overview of the work she has been leading that has been building off of our experiences with all of the disasters, basically an all-hazards approach.

And she will also be revealing feedback that we have received from stakeholders as part of the way we've gone to this point in time.

After that, we would like to stop talking as Dr. Davis said and we would prefer to listen to your ideas. And we would begin receiving your feedback on the five questions that were posted in the agenda yesterday that we sent out to you.

But we will not be able to comment on the feasibility of your ideas and suggestions. As Dr. Davis said, we will seriously consider them as we move the process forward.

Thank you.

Sue?

Susan Larsen: Thanks Peggy.

As Peggy noted, I am the Survey and Certification Emergency Preparedness lead. And following Hurricane Katrina, under the direction of our Director, Thomas Hamilton, the Survey and Certification Group took a very robust and widespread directive to be looking at ways to improve and enhance our current emergency procedures and protocols.

And we rolled out this initiative back in spring 2006 and first worked with all of our - internally within our Survey and Certification Group and involved various work groups with representatives from both central office and our regional offices and really looked for ways to thoroughly analyze and review all of our current policies and procedures and look at any gaps and holes and methods that needed improvement.

And we did as Peggy noted take an all-hazards approach and looked, you know, at all of the various factors of hurricane, tornado, earthquake, fire, flood, et cetera.

But I would like to note that mass casualty planning was not one of our particular focuses during this effort.

We established a variety of work groups who looked at issues such as interagency roles and responsibilities, information technology infrastructure, communication and outreach, monitoring and enforcement, education and training, and developed recommendations for all of those aspects.

And then in fall of 2006, we invited a large group of stakeholders, approximately 50 stakeholders, to participate in our Survey and Cert Emergency Preparedness Communication Forum with the purpose of disseminating information, rolling out the recommendations, and gathering

input and feedback and really looking at gleaning information from the experience out there in the field.

The representatives included state survey agencies, accrediting organizations, provider associations, patient and resident advocates, quality and safety organizations, and representatives from our partners at Health and Human Services Operating Division.

And we held monthly teleconferences with these stakeholders and dialogued on all of the various issues and recommendations that each work group had developed.

One of the work groups, our provider guidance and standards work group, was the group that thoroughly analyzed our healthcare provider standards and policy and guidances.

And they prepared a - after their analysis a variety of recommendations for improvements to that area. And as part of their recommendations, it was determined that it would be wise to be looking at improved emergency preparedness regulations. And they have developed recommendations for some of the improvements that should be included in that area.

And as many of you may be aware, there is on the docket a proposed omnibus emergency preparedness regulation that is under current development that will be looking to having consistent and improved emergency preparedness regulations that would apply to participating Medicare and Medicaid certified healthcare facilities and agencies. And that's NPRM or notice of proposed rule making. It's targeted for issuance in summer of 2008.

Another one of our work groups who looked at monitoring and enforcement requirements also thoroughly reviewed all of the current waivers and flexibilities that CMS has under its authority during an emergency situation.

And different from some of the areas within CMS and within HHS, the Survey and Certification Group has responsibilities not only during a wide scale disaster, but also during localized events that, you know, pertain to just a small location or even one facility. So here is a wide range that was reviewed and discussed.

We did produce a variety of documents and also established a Survey and Certification Emergency Preparedness web site as part of this overall initiative.

We have prepared a variety of emergency preparedness checklists that give hints and tips for planning and response efforts, as well as an updated survey and cert emergency preparedness - survey and certification frequently asked questions that is for declared public health emergencies for all hazards.

And that FAQ document was issued under a survey and cert letter last fall in October, but it's also posted on our Survey and Cert Emergency Preparedness web site, which can be accessed at www.cms.hhs.gov/surveycertemergprep. That would be E-M-E-R-G-P-R-E-P.

And so there has - this has been just a wonderful experience working with all of these stakeholders who are at the same table discussing issues and concerns that have occurred during disasters.

We have experts across the nation. And it is especially interesting to - because we've been looking at all provider types at the at the impact that one provider type may have on another.

So with that, I think that provides my high level overview. And Tim, I'll turn it back over to you to be launching into the questions.

Natalie Highsmith: Okay. Thank you, Susan.

Okay, so now we're going to go ahead and move into our first question, which is listed on the agenda that is posted on the Special Open Door web site. We're going to ask that anyone who has a response to the first question, which is what budget-neutral steps are necessary or desirable by HHS and/or CMS to improve private sector healthcare facility preparation for such mass casualty events?

Anyone who has a response to the first question and the first question only, we ask that you go ahead and get into the queue to answer that. And please remember to restate your name, what state you are calling from, and what provider or organization you are representing. And please remember to keep your responses to no more than two minutes so we can move quickly through the remainder of the questions.

(Lori)?

Operator: Yes, again, please, to signal for - press star-1 on your telephone keypad.

We'll go first to Cynthia Flynn in Washington.

Cynthia Flynn: Hi. My name is Cynthia Flynn. I'm President of the American Association of Birth Centers.

We've been trying for some time to get birth centers listed as reimbursable facilities by CMS. And we are the experts in (out of) hospital birth in times of mass emergency. (Unintelligible) we don't want healthy mothers and babies in hospitals, because there are contagious diseases there.

We would prefer to have them out of hospital. And CMS can do a lot to A, reduce their immediate cost because birth centers are less expensive than hospitals, and B, provide a place for women to go in times of emergency other than the hospital, where they can receive safe care for childbearing.

And we would very much appreciate if the CMS rules could be changed by just two words, by adding birth centers to the list of approved facilities for payment.

Woman: Thanks very much, Cynthia. We appreciate your feedback.

Operator: We'll go next to (Paul Miller) from Louisiana.

(Paul Miller): Yes, can you hear me?

Woman: Yes, we can

(Paul Miller): This is Dr. (Paul Miller) calling on the budget neutral question. The DIPP sites, D-I-P-P, Disaster Information Public Post, an expansion of the Emergency Broadcast System, is essentially that in mass disasters or just like what happened in Katrina here that you - the Emergency Broadcast System essentially fails in regional areas, even with backup communications now.

The need to have the public/private type of government affiliations at the areas along exit routes, gas stations and Home Depot, Lowe's, et cetera, that have generators and have communications that the regional or government entities can communicate and post public boards so that the patient population that is evacuating can actually go to these sites and not flood hospitals and flood the emergency systems and bottleneck the acute areas.

And so essentially these would be disaster information public posts that would be communicated through these alliances in advance to be able to post information at all exit sites so that mass evacuations would not have to bottleneck acute areas or emergency preparedness areas.

The second thing is that I would suggest in budget-neutral status that there offer at least - the government should offer sites satellite communication ability, at least a cheaper route for these emergency - like we're a dialysis facility. To offer us an ability to tap into those resources at our own expense, but reduced if were grouped together for a group rate.

And so that's the two suggestions that I have and thank you.

Man: Thank you, Dr. (Miller).

Operator: Again, if anyone has a response, please signal by pressing star-1.

We'll go next to Marcie Roth in Maryland.

Marcie Roth: Hi. This is Marcie Roth and I'm co-Chair of the Consortium for Citizens with Disabilities Emergency Management Task Force and also with the National Spinal Cord Injury Association.

And a budget-neutral suggestion that I would make would be to work with all of the sheltering initiatives to make sure that shelters are able to meet the additional needs of people with disabilities so that they feel more capable and less in need of referring folks to med/surg environments where these are folks who might typically be living independently or living with family support and who don't need to be - as was described with other groups, don't need to be in the med/surg facilities if, in fact, the shelters are able to do as they're required under the ADA to meet their ongoing shelter needs.

Thanks.

Man: Thank you.

Operator: We'll go next to Jocelyn Montgomery in California.

Jocelyn Montgomery: Hi. I am the Director of Clinical Affairs at the California Association of Health Facilities. We represent skilled nursing facilities and intermediate care facilities for the developmentally disabled.

And I think the provisions that are set forth in your frequently asked questions in terms of looking to loosen the requirements on a three-day stay as a qualifying requirement for people to enter skilled nursing needs to be addressed in a more formal way for local disasters and something that allows for pre-planning.

We really support the idea of our facilities sending their patients to like facilities in a disaster, but they need to have some assurance that there will be reimbursement and a way to preplan for that, not just after the fact.

Man: Thank you.

Operator: We'll go next to Rich Kaiser in North Carolina.

Rich Kaiser: Yeah, hi. I'm president of a company that subcontracts computer services to CMS.

Specifically when we were speaking about communications and facilities' ability to access resources, I just wanted to point out we did some work after Katrina and the - specifically the communications services for broadband, so that was the Internet service, that was donated by a local phone company so that we could use that and offer that through people, the facilities, victims, relief workers. We just opened up our network and let everybody get on for free.

And so that's a budget-neutral aspect of disasters is that if things are in an ad-hoc mode where things are just being strung together and pulled together, it's a very lucrative and optimized cost savings if we exploit the no-cost and low-cost features that are going to be coming anyway just for the fact that a disaster is occurring.

Also wanted to point out that Vonage, they donated long-distance phone service on this network so that everybody who could touch our network could call out to anywhere in the United States for free.

So if this network had to cover these costs by themselves, I don't think the network would exist. But during an emergency, because of the donations involved, these services were free to everybody.

And that was my point, (just to), you know, perhaps factor in and anticipate that as a situation escalates, other resources will become available.

Man: Thank you.

Operator: We'll take our next comment from John Rigg in California.

John Rigg: Hi. This is John Rigg. I'm actually -- I'm sorry, I work for the California Hospital Association, but I'm actually based in Washington, DC.

I have a comment. I see that we're discussing preparation right now and we'll discuss emergency response later, so I'll chime in later with additional suggestions if you think that that's appropriate.

But with respect to preparation, I think one anxiety that I have, especially in the wake of a wildfire disaster we recently had in Southern California is that happened to affect more rural areas, as you might imagine, is in regards to critical access hospitals and bed limits.

As you know that there's a fairly restrictive limit on the number of beds that critical access hospitals can have, which certainly has implications for emergency response.

But in terms of preparation, I think it might be helpful if CMS would allow critical access hospitals to still conform to those bed limits while keeping some - perhaps a wing out of the hospital, particularly if they're in an area that's susceptible to emergencies, ready to handle a large influx of patients or some considerable influx of patients that relate to an emergency.

I think under existing code that that would put these - that would put the hospital over the bed limit and thus endanger their critical access hospital designation.

But if - I think that it would protect the program's integrity and still conform to the spirit of the law if those beds were allowed to be kept in reserve in case of a Stafford Act emergency or a public health emergency, whatever specific type of emergency would be more appropriate.

Man: Thank you, Mr. (Reagan).

John Rigg: Rigg.

Man: Rigg, okay.

Operator: We'll go next to Jim Mackin in Arkansas.

Jim Mackin: Well, that's Alaska, not Arkansas. We often get confused, although we're not very close.

Yeah, I'm with the Department of Health and Social Services here in Alaska. I'm the Public Health Preparedness Director.

In keeping with the budget-neutral concept, just to make sure that everyone is aware of these in case that's not true, the ASPR, Assistant Secretary for Preparedness Response, CDC, and Homeland Security all have programs to support medical/surg, which is what we're really talking about here.

In particular, ASPR has a hospital preparedness program, goes out to all of the states. There are dollars there. CDC has a general preparedness program for

public health, but many of the goals of that particular program coincide closely with those of the hospital preparedness program.

And specifically within the Department of Homeland Security, they distribute the MMRS, the Metropolitan Medical Response System, grant to communities that are participants in that program.

One of the shortcomings that we see in the states is a lack of coordination between those agencies. And because of that lack of coordination, we often don't see economies of scale where we can appreciate the benefits of synergy by working those programs together.

We do that at the state to some degree, but I think we could achieve even greater benefit if folks at the federal level were working more closely with one another to see how they can use those existing programs to augment our medical/surg capacity programs down through the states and into the county level.

Thank you.

Man: No, thank you.

Operator: All right, we will go next to (Lowell Feldman) in New York.

(Lowell Feldman): My name is (Lowell Feldman). I'm representing the American Healthcare Association (Disaster Planning Committee) made up of oh, hundreds of thousands of nursing home - skilled nursing home beds.

I think the area of education is quite important and under-funded, especially in the private sector of skilled nursing where our nurses and medical and paramedical personnel are really not prepared for super emergency situations.

And I believe to keep it budget neutral, maybe making grant funds more accessible to the private sector, which has been quite difficult in the past, to train our personnel more proficiently in the area of disaster response. We're expected to provide services during disaster, but have very limited access to funding streams for disaster preparedness.

In addition to that, the during and post-disaster, again in private sector, this industry is not on a level playing field with things like FEMA for access to funds to prepare and more so for future disasters after having experienced disasters. We don't have access to those funds as not-for-profit organizations do.

So, again, just to recapsulate (sic), the preparing through education and grant access funds and then the level playing field for reimbursement in the event of disasters.

Thank you very much.

Man: Thank you.

Natalie Highsmith: Okay, (Lori), we have time for one more question. I mean, one more answer, I'm sorry.

Operator: Okay, we'll go to Rachel Hammon in Texas.

Rachel Hammon: Hi. My name is Rachel Hammon. And I'm with the Texas Association for Home Care.

And one of the things that we noticed during Hurricane Rita was an issue regarding the special needs shelters and the ability of unlicensed staff who work in those special needs shelters to meet the activities of daily living needs of the individuals who are housed in those special needs shelters.

And so as a suggestion, budget-neutral suggestion, rather than requiring only licensed or licensed-only individuals that are able to work in those facilities, possibly allowing for MOUs between home health agencies and special needs shelters to utilize unlicensed staff in their facilities to assist with the care needed during those times.

Man: Thank you.

Natalie Highsmith: Okay, we have reached our designated time limit for the first question. I do apologize if you were anticipating on getting your answer on the line. However, we might have the time at the end of the call.

But now we are going to move on to question number 2 as listed on the agenda. What other financial or non-financial incentives might be created or barriers removed that would facilitate emergency preparedness and response in mass casualty events while potentially shifting but not increasing costs.

We're going to take responses to question number 2 now.

Operator: Again, to respond, please signal by pressing star-1 on your telephone keypad.

We'll take our first response from (Paul Miller) in Louisiana.

(Paul Miller): Yes, ma'am. And I'd like to suggest that what I mentioned before, the satellite communication service, if there were a reduced fund, for those of us who do disaster preparedness in the private sector that we should be able to have communications.

And in large mass evacuations, oftentimes the overloaded circuits and just simply whatever the circumstances are, there's no communications. And again, as I mentioned before, the go-to safe sites like the DIPP sites so people can go to.

The third thing I would say on that is that if there were an ability for like we're in the dialysis community, for us to be able to do our own transportation service, that would not be budget neutral, obviously. Well, maybe it would be because it would be a shift from what it is now.

It would allow responsibility for each unit or each service to be able to transport patients into safe areas without having to wait for the response. And that would be, you know, other than that, tax breaks for generator or other types of assistance, that would be my suggestion for that.

Thank you.

Man: Thank you.

Operator: We'll go next to Roslyne Schulman in DC.

Roslyne Schulman: Hi. This is Roslyne Schulman. I'm with the American Hospital Association.

A couple of ideas here and they're may be over - going over a couple of questions here. One is with regard to the hospital, the federal funding available to hospitals under the ASPR Hospital Preparedness Program, there are some concerns about that program with regard to the fact that while the funds for those programs have been decreasing over time, the administrative requirements that - and some of the more burdensome requirements included in those grant guidances that would be imposed on hospitals have been increasing.

So one suggestion we have is that ASPR should look at the requirements contained in the grant guidance and drop those that might have some limited merit and don't really have - and focus more on those that do have merit and have proven value.

The one example I would give here is some of the - in recent grant guidances, there have been requirements for hospitals to have their staff complete certain training requirements to comply with the national incident management system now. And there are sort of threats down the line for those training requirements to be increased.

There is really - I mean, there's sort of an overall view that those requirements have really limited benefit and they're really not all that applicable to hospitals. And so we do believe that HHS ought to look very carefully at increasing any kinds of training - (NIM)s in particular, training requirements and just focus on the merit of anything that is required.

Also with regard to CMS kind of issues, we would - we do appreciate the flexibility that CMS showed in the wake of the Gulf Coast hurricanes and would encourage them to move forward with sort of in advance taking some steps to improve hospital preparedness and response, things like developing

templates for documenting clinical care and expedited claims forms that involve only minimal required elements that could be used in disasters to smooth payments, loosening the rules around expedited and advance payments in disasters. There are currently very restrictive rules for expedited and advance payments.

And so provide some additional flexibility there so facilities that are having temporary declines in patient populations or other difficulties would be able to have access to funds to continue to allow them to be up and running.

There - also we would suggest that CMS develop a process in advance of the next disaster to allow claims for services that are provided in locations that are nontraditional locations such as alternate care centers or field hospitals, put a process into place to allow claims to be submitted from those sort of nontraditional locations in an expedited kind of a way.

And finally, put into place a process that would allow for claims to be accepted for services that are provided by healthcare professionals who in normal circumstances wouldn't be able to - by Medicare to be able to provide services to beneficiaries.

So that would be situations such as maybe nurses providing care that's typically provided by physicians or residents or medical students providing services without the currently required level of physician supervision.

Thank you.

Woman: Thanks, very helpful.

Operator: We'll go next to (Scott Cormier) in Tennessee.

(Scott Cormier): Hi. I'm (Scott Cormier). I'm the Director of Emergency Preparedness and Management for the Hospital Corporation of America. And we have 170 hospitals that I oversee emergency preparedness for.

I see two barriers that we'd like to see help with. The first is the movement of our supplies. We have a large distribution system. And in the past during the hurricanes in Florida and Louisiana, we've found it very difficult to move our supply caches to our hospitals due to local regulations.

The second thing we have a concern with is during those incidents as well, federal agencies came in and commandeered our supplies. And it just doesn't make sense to me that if I'm using my supplies to take care of 500 of our patients, why the federal government would need to take our supplies to take care of 500 other patients.

The third thing is possibly an incentive, but in large healthcare corporations like us, would it be feasible to place some of these emergency preparedness supplies that the federal government has within our supply chains and distribution centers to make it easier to get these out in an emergency.

Thank you.

Woman: Thank you.

Operator: All right, we will go next to Janice Zalen in DC.

Janice Zalen: Thank you. I'm Janice Zalen with the American Healthcare Association.

And I'd like to first echo what Roslyne Schulman from American Hospital Association and Jocelyn Montgomery from the California Association of Healthcare Facilities said before and that is the importance of CMS having in advance templates that clarify what happens in an emergency, what restrictions, what requirements are going to be alleviated and not needed to be followed during an emergency, what will be different, what will be the same, increasing ways to improve reimbursement, make it faster, as Roslyne said.

And by doing that, then the providers themselves, it will make it a lot easier for them to plan because they know what the rules and regulations will be in an emergency situation. So I think that's really important.

I also wanted to bring up (ASPRA) and their grants. And I know Roslyne mentioned something about they're getting very burdensome.

One problem that we long-term care facilities have with those grants, they originally were for hospitals. They are for long-term care facilities now, too. And we were very excited and planning to try to utilize some of those grants to help improve preparation for long-term care facilities. We had a speaker from (ASPRA) come out to a meeting we had prior to the grant coming out to tell us about it and so we were really looking forward to it.

And then when the grant notice came out, it was an amazingly short period of I think it was 30 days. And you also needed to have been pretty well ready to work. It was a grant to work together with other agencies. And that's a good idea because you need to have coordination and communication.

But you almost needed or maybe not even almost. You actually did need to already be working with the other agencies or associations before the 30 days because there would be no way to have put out a grant application together.

So what I'd like to see if (ASPRA) could either do some technical assistance prior to putting out a grant award announcement or increasing the amount of time and also looking not so much for places that are already doing it, but how to help places that are not so that they can really get a good start.

Thank you.

Man: Thank you.

Operator: We'll go next to (David Gerschner) in Ohio.

(David Gerschner): Yes, I'm the MMRS Coordinator in Dayton, Ohio.

I'd like to mention a program called SLEP, which is Shelf-Life Extension Program, which is managed by the FDA and the Department of Defense.

SLEP enables the Department of Defense to purchase drugs, periodically (have) those drugs, which are purchased for storage against mass casualty incidents, have those drugs periodically tested and then have the shelf life extended, sometimes by as much as a factor of four or five, so drugs which would otherwise expire in two years are actually good for up to ten years.

There are many facilities, hospitals, local agencies, state agencies, that are stockpiling drugs such as antibiotics, anti-nerve agent drugs, antivirals, against mass casualty incidents.

And those drugs are not eligible for SLEP and therefore expire and need to be replaced on a fairly frequent basis. If we could simply open SLEP up to other

agencies and private organizations, this would save a huge amount of money for all of the agencies participating.

Thanks for the opportunity.

Man: Thank you.

Operator: We'll go next to Marcie Roth in Maryland.

Marcie Roth: Hi, Marcie Roth, National Chronic Injury Association and Consortium for Citizens with Disabilities again.

There are some really important opportunities for CMS to not only cost shift but to save a tremendous amount of money. If NDMS were to add additional teams called disaster disability assistance teams, similar modeled to the DMATs, those disability experts could supplement in federally declared disasters, addressing the additional needs of people with disabilities.

And it could reduce the disproportionate use of acute medical facilities for those folks and as well reduce the secondary complications that many people then experience when they're not getting their disability-specific equipment and services.

It would free up the first responders to focus on what they do best. And these teams could be ready to deploy very similarly to the DMATs. They could use the very same model that currently exists, the same federal law that federalizes those folks.

And we would really welcome the opportunity to talk more about how we could mobilize these volunteers who have particular expertise and could save

CMS and the taxpayers a tremendous amount of money, keep people out of those facilities.

Man: Thank you.

Operator: We'll go next to Rich Kaiser in North Carolina.

Rich Kaiser: Hi, it's Rich Kaiser. I'm the President of SoftDev, Incorporated.

I was just going to make a simple suggestion and it's very quick but that advertisement and promotion of disaster preparedness would be something that becomes a regularity and a familiarity with people because I know that four or five more people than what are involved in this phone call are considering disaster preparedness only because I am aware of this phone call, I spoke to them about it.

So I think the same kind of extrapolation could occur across, you know, the entire nation. If there is advertisement or a general theme of considering disaster preparedness, people tend to then become more aware of it through peripheral or side-effect exposure to disaster preparedness. And that's my point.

Thank you.

Man: Thank you.

Operator: We'll go to (Bill Birthrong) in Virginia.

(Bill Birthrong): Hello.

Yeah, this goes to the removal of barriers issue, too. I would look for support from HHS to eliminate any remaining federal, state, or local government restrictions that might prohibit or reduce the level or type of support that a local, state, or FEMA could provide a private sector hospital or nursing home in a - in the event of a declared emergency.

In other words, currently local (EOC)s, state (EOC)s, and FEMA are reluctant to provide material assistant to hospitals and nursing homes in an emergency and those barriers need to be removed.

Thanks.

Man: Thank you.

Operator: We'll go to Jim Mackin in Alaska.

Jim Mackin: Hello again.

Just very quickly, amen about everything that everyone has said so far. Those are great ideas. Since I deal with state government in the Department of Health and Social Services and manage the grants that come out of HHS and CDC, one of the things - while this may sound strange, but one of the things that would help us a great deal direct more of the available dollars to where they need to go would be a cap by ASPR and CDC similar to what Department of Homeland Security has done for indirect and administrative costs.

We - the amount of indirect costs that the state absorbs for these grants is generally left up to the states. That indirect cost is often then again reflected at

the local level when we push the money out from state government to local government, the overall cost of the grant is significant.

If we could cap that at - as Homeland Security does, cap our indirect cost at 5% total, I think we not only solicit funds from local government, et cetera, but we make significantly more money available to the - directly to the programs and get it out to the tip of the spear where it's needed.

Thank you.

Operator: We'll go next to John Rigg in California.

John Rigg: Hi. It's John Rigg again.

On this point, I have a couple of suggestions. The first actually is very close to my prior suggestion about bed limits on critical access hospitals. I think in the event of an emergency, it's completely reasonable to expect some flexibility or I think some flexibility should be accorded to critical access hospitals in the event of not just an emergency, but also a - in their catchment area a large, multi-casualty sort of emergency where there's a lot of injuries from an automobile wreck or something along - of that nature.

I would also suggest a average wage index changes in the event of a catastrophic national - in the event of a catastrophic sort of a disaster. I spoke a couple of years ago to my colleagues in Louisiana and I believe that they were having difficulties because though their labor market had changed substantially, the area wage indexes is based off of prior year's data, so the changes to the labor market and the difficulty (it was) to find workers and housing for workings in the area - in the Katrina-affected area had affected the

labor market substantially, but they weren't being compensated through Medicare for those labor-related changes.

Also to echo what Roslyne Schulman with the AHA -- of which we agree with all of their comments and support them fully -- I would also add that interpretive guidelines that I've seen, they're primarily in draft form right now, but they were put out in early February by Survey and Certification.

The interpretive guidelines around verbal orders and verification I think could use some flexibility. I think it's unreasonable in the event of an emergency for a patient's hospital or the physician that is responsible for a patient in a hospital to respond to the hospital simply to sign orders within a certain time frame, whether they were verbal or otherwise. So I think that there could be some work around that.

I know that this also touches on nursing scope of care and I heard a prior - a previous commenter mention that -- and I think it was also Roslyne Schulman -- that nurses and other non-physician providers should be allowed a broader scope of care in the event of an emergency, which is an aspect of those comments with which we'd also strongly agree.

I'll have more comments later when we have questions that are more germane to other topics.

Thank you.

Operator: We'll move on to Jocelyn Montgomery in California.

Jocelyn Montgomery: Yes, can you hear me? Hello?

Operator: We hear you, Ms. Montgomery. Please go ahead.

All right, we'll move next to Wendy Schrag in Kansas.

Wendy Schrag: Hi, this is Wendy. I work for Frisenius Medical Care. Wanted to build on Dr. (Paul Miller)'s comments about transportation, especially for dialysis patients, but might apply to other healthcare providers as well.

I think working through partnerships with other agencies that provide transportation or have transportation vehicles or drivers that might be available that don't necessarily have anything to do with healthcare, but, for instance, the schools aren't open, some churches have vans, just ways that maybe the communities, the departments of health, could help link agencies with each other to create partnerships that they could work with during emergency events to help with transportation needs.

Natalie Highsmith: Okay, thank you. We have time for one final question.

Operator: Again, if anyone has a comment, please signal by pressing star-1.

No further comments on this subject.

Natalie Highsmith: Okay, well, we will go ahead and move into question 3, which is what specific CMS requirements, policies, or other flexibilities, if any, might be necessary or desirable to remove impediments to private sector healthcare in such an emergency?

We can take comments for question 3 now, please.

Operator: Thank you. Please signal by pressing star-1.

We'll go first to (Scott Cormier) in Tennessee.

(Scott Cormier): Yes, I'm wondering how value-based purchasing is going to affect the care and reimbursement that we get during a disaster.

Thank you.

Operator: We'll go next to John Rigg in California.

John Rigg: Hello.

I think this may be the last you'll hear from me. A couple other topics -- we noticed in Southern California around the wildfire disaster that there seemed to be impediments with respect to information flow that would justify or not justify as it turns out a public health emergency that would sit on top of a Stafford Act emergency. So I have a couple of comments around that.

I'd love to see better coordination between ASPR and FEMA or whoever it is that declares the Stafford Act emergency and better coordination of sort of data flow between those agencies and also between ASPR and CMS.

We were asked and our members were asked several times during this emergency and previous emergencies for sort of data around for what they're seeing on the ground in their communities.

And we know that those data are already being collected under the auspices of the incident command system. We - I think we would strongly suggest that CMS and ASPR develop a list of data needs that are - that sit on top of that which is already currently collected in the incident command system so that it

would sort of short circuit that process and we wouldn't have to go through this back and forth in the event of subsequent emergencies.

I know that that will also involve the state, so a second and sort of ancillary suggestion is better coordination between CMS, ASPR, and the state to coordinate.

Finally, I think we would like to see perhaps better - more flexibility around EMTALA and EMTALA waivers. I know that there's a 72-hour limit except in the case of a - of that waiver except in the event of a public health emergency around pandemic flu, I believe.

I think that CMS should consider broader waivers or more flexible - more flexibility in that regulation around other public health emergencies, simply because something like a wildfire disaster, for example, could isolate a hospital for longer than 72 hours from being able to affect an appropriate EMTALA-compliant transfer or may need them to conduct the transfer more quickly than would otherwise - or a non-EMTALA-compliant transfer for longer than 72 hours.

So and I think that's all I have for now. Thanks so much.

Natalie Highsmith: Thank you.

Next answer, please, comment, please.

Operator: We'll go to Roslyne Schulman in DC.

Roslyne Schulman: Hi, this is Roslyne again.

A couple - in addition to the things I mentioned before about expedited claims processing and expedited process for reporting clinical documentation, also one of the issues that arose in Katrina was related to non-disaster states.

And in states that are (outside of the sort of) official disaster area, but which do accept evacuees or people from other facilities within a disaster area, it would be helpful to be able to waive Medicare requirements for those hospitals and other providers who do treat those victims of disasters.

Thanks.

Oh, and wait, one more things, sorry. The other thing I wanted to mention was currently FEMA public assistance, disaster assistance funding, this gets more at recovery than preparedness or a response, but currently that FEMA funding is only available to private not-for-profit facilities, but not to investor-owned or for-profit facilities.

I would argue that in a disaster, for-profit facilities provide the same kinds of community services that not-for-profit facilities provide and should have access to those kinds of disaster-assistance funds.

Natalie Highsmith: Thank you.

Operator: We'll go next to Jocelyn Montgomery in California.

Jocelyn Montgomery: Yes, can you hear me?

Natalie Highsmith: Yes, we can.

Jocelyn Montgomery: Oh, thanks.

Building on what I said before about a qualifying three-day stay being something that I think should be pre-waived in the event that certain conditions are met that constitute an emergency and not necessarily a presidential declaration, another thing that I'd like to see CMS do is to develop a emergency admission procedure so that we have guidelines to follow if we are receiving facilities outside of an emergency area or even within an emergency area, but were not impacted and we want to take in dislocated residents from either a skilled nursing facility or an intermediate care facility, or even the medically fragile in the community who would be well served in a nursing care environment.

Another thing I'd like to see CMS look at is a clarity on the trigger for an evacuation. I think there's a lot of fuzziness in the minds of healthcare facilities about when they should go, how soon they should implement an evacuation procedure knowing that it will take them hours to get away and yet, you know, should they wait for the mandatory order to go and then it's too late, those kinds of issues.

And then a third are standards for repatriation. During the San Diego fires, we had facilities that were put on hold because of the state licensing agency having a criteria that was unknowable to the providers but yet they would come in with some kind of standard and tell providers whether or not they had met that standard. You know, that really needs to change. And I think it could be something that was federally guided.

Natalie Highsmith: Thanks.

Operator: We'll take our next question from (Ken Daley) in Ohio.

(Ken Daley): Hi. I'm (Ken Daley).

And my only question or comment would be related to the Stafford Act. It should be expanded to allow for disaster response recovery funds for all types of providers, not just those that provide for care in - who are non-for-profits.

Thanks.

Operator: Thank you.

We'll go next to Rich Kaiser, North Carolina.

Rich Kaiser: Yeah, it's Rich Kaiser. I'm President of SoftDev in North Carolina.

And I just wanted to pass along something that all facilities, so I don't know if CMS can make a regulation because it would be really helpful if everybody had a buddy system.

When we were down in Mississippi, we had - it took about a month before we started looking for people. In a month, we handled all of the people that were coming to us requesting communication services. And so we scrambled for a month.

What surprised the heck out of me was that after that month was over, we started going out and we were the only team that was looking at towns and places, facilities where nobody had heard from them.

And the point is that disaster relief organizations are based on the requests for help. And no other organization is mandated to go look for people who haven't been able to call out for help.

So I would just suggest that facilities consider and CMS recommend that facilities have a sister facility or somebody else so in a worst-case situation at least there's a chance somebody might go looking for them.

That's all. Thank you.

Operator: Again, if anyone has a comment, please signal by pressing star-1.

And at this time, there are no further comments.

Natalie Highsmith: Okay, well, we can go ahead and move on to question 4, which is what existing US government grant programs might usefully be targeted and modified in part to assist healthcare facilities through state and local health officials and departments to improve preparedness for these mass casualty events.

We're taking comments on question 4, please.

Operator: Again, to signal, please press star-1.

We'll go first to (Paul Miller) in Louisiana.

(Paul Miller): Yes, ma'am.

As far as existing grants that are available to help DHH and other areas, well, in - specifically in our field and in others, we have not addressed safe water. We've not addressed safe reservoir sites that can be combined in municipal water or even with dialysis facilities that allow deeper aquifer type of reservoir sites.

When a mass evacuations occur, if the water's contaminated in any particular area, if you have explosions or even in like what happened with the saline surge of Katrina, what happens is there's whole large areas of water are out. The tankers that bring in backup water are out.

So what I would suggest is with grant money that are available through (FDA), through the safe water act, and through other DEQ programs and (OSEP) is that they look more at areas, whether municipalities, other areas that can utilize those grants to be able to provide go-to sites during disasters for evacuating people to be able to have safe water because it won't be providing those areas with large volumes, but it would simply be safe water for them to be able to get (unintelligible) large area is contaminated, that's going to be our greatest risk.

Thank you.

Natalie Highsmith: Okay, thank you.

Operator: Janice Zalen in DC.

Janice Zalen: Thank you.

One thing we haven't addressed very much I don't think is the employees that need to be trained as well as they need to be trained in advance and then they need support after emergencies. And I'm wondering if the Department of Labor doesn't have some grants that could be steered towards that kind of use.

Thanks.

Operator: We'll go next to (Louis Ranizerski) in New Jersey.

(Louis Ranizerski): How're you doing? (Lou Ranizerski) calling from Atlantic Care Regional Medical Center in New Jersey, also a paramedic and I do a lot of special operations and assist the hospital with some emergency planning aspects.

The concern we have is is that some of the grant funding that comes down through the states that comes down through the US government, a lot of it is mainly geared to municipalities.

And because hospitals and in our case in New Jersey paramedics are mandated to be hospital-based. A lot of times we don't receive some of the grant funding for personal protection and other preparedness equipment and supplies that some of the municipalities do.

And the suggestion here is to maybe open those grant funding opportunities up in certain aspects to the private sector that deals with healthcare preparedness and in those cases 9-1-1 response.

In addition, possibly look at not only the threat assessment in some areas that receive a lot of the grant funding, but also, you know, maybe to make sure that in order to get everyone on - up to speed on preparedness that not, you know, certain areas or, you know, certain states to receive all of the money.

We have a lot of, you know, areas that are trying to be proactive and trying to be prepared, but because of lack of grant funding, they're unable to.

Thank you.

Operator: We'll go next to Wendy Schrag in Kansas.

Wendy Schrag: Hi.

I don't believe we have mentioned pandemic flu yet. And I believe that a lot of the state health departments and county health departments have special grant funding to be working on pandemic preparedness now in their communities.

And I'm - I co-chair the pandemic response team of the kidney end-of-life - or kidney emergency response coalition. That's looking at just nationwide for dialysis patients.

So I would like to encourage health departments all the way down to the county level to be more vocal and active in their communities around what they're doing and to have publicized meetings where the community and different health providers can come and meet and start working more in tandem with the county health departments on pandemic preparedness planning.

Operator: We'll move on to Thomas Grace in Pennsylvania.

Thomas Grace: Good afternoon. I'm Tom Grace. I'm with the Delaware Valley Healthcare Council, with the Hospital Association of Pennsylvania.

And the suggestion I would have is that the Department of Homeland Security critical infrastructure funds be available - made available for improvements in critical infrastructure of healthcare facilities as well.

At least our state director of Homeland Security has told us that those funds are available only to government-based agencies and as a result we really see no funding stream to improve security of facilities over the past seven, eight

years with all of the different funds for improved security, recognizing that hospitals and healthcare agencies are critical infrastructure by their definitions.

And also the issue around mitigation, if we had the ability to attach outside or external emergency generators in case of internal failures or something like that, we could avoid some evacuations.

So again, from a mitigation standpoint, making those funds available to hospitals and healthcare facilities would prevent a lot of problems that often happen downstream of the event.

Thank you.

Operator: We'll go next to Shelly Raffle in New York.

Shelly, if you're using a speakerphone, please check your mute button. We're not able to hear you respond.

Shelly Raffle: Yes, hi. This is Shelly Raffle. I'm calling - with the Visiting Nurse Service of New York. I'm our Emergency Coordinator.

And we represent a population that's about the size of the state of Rhode Island, which goes to say that grant funding in all of our searches is pretty much nonexistent in addressing homecare populations, and that's whether it's emergency preparedness for or staff preparedness in homecare agencies or coordinations between hospitals and other community-based healthcare organizations.

We find that certainly in our state, the predominant if not the complete funding stream is directed towards hospitals and yet, you know, in talking about issues related to surge capacity, you know, there is not that coordination happening between the hospitals and the communities that are receiving the discharges from those facilities.

So I think that as CMS is looking at modifying the availability of funding streams, looking towards the support of those agencies who are keeping people out of the hospitals needs to be addressed. We feel - I think we feel pretty invisible and - in those terms and so yet I think that it's a critical aspect of the healthcare community.

Thank you.

Operator: We'll go next to (Lowell Feldman) in New York.

(Lowell Feldman): Yes, thank you, again. I'm with American Healthcare Association (Disaster Planning Committee).

And I want to mimic on the aspect of co-generation and outside energy sources. Many of our facilities are extremely structurally sound and can withhold disasters and would be relied upon to take in outside patients.

And the ability to provide multiple generator sources would be a wonderful event in the event the disasters were prolonged and deliveries of fuel couldn't be made, we could run on our co-generation gas and oil.

I believe grant funding, there is some statewide available, but more available on a federal basis for existing facilities to have energy alternatives. And I

think eventually would fund itself by having reduced year round energy costs in non-disaster situations.

That in addition to the availability of necessary equipment and stockpiling of everything from pharmaceuticals to durable medical equipment, not necessarily onsite at individual facilities, but certainly within large catchment areas, my health facility happens to be in the Bronx, so we have I believe more healthcare beds than many states do and hospital and nursing homes.

And there would be a scurry for available equipment and apparatus and especially during a pandemic where there would be insufficient number. So I think there has to be some attention paid towards ongoing development of a program to begin stockpiling all types of equipment and apparatus and pharmaceuticals.

Thank you.

Operator: We'll go next to Jocelyn Montgomery in California.

Jocelyn Montgomery: Yeah, I don't know if this is true across the country, but in California, we have a pretty advanced system of patient tracking and the dispatching of transportation resources, but it's really between the emergency medical services agencies and the hospitals.

And I would suggest that grant funding be made available to tie non-hospital facilities in to those existing networks that are web-based, electronic tracking systems already in place.

They don't currently include - in many counties at least, they don't currently include nursing homes. And I think that there are other facilities that've been

mentioned on today's call that would - it would be considered an asset and should be tied in.

So I'd like to see some patch funding to encourage that kind of coordination, and especially when it comes to transportation resources, which we all scurry for at the same time and are competing with each other to get.

Operator: We'll go next to (Angela Scott) in New York.

(Angela Scott): Hi. I agree with Shelly. I am an occupational health nurse from Lifetime Care Home Health agency. And I'm trying to find grants to help us with any patient surge that could be coming out of hospitals during a disaster of some sort, but there don't seem to be any grants available. So I would recommend that grants also be allowed for home care agencies.

Thank you.

Operator: We'll go next to (Wendy Apgar) in Missouri.

(Wendy Apgar): Hi, yes, I'd like to recommend that individuals in healthcare become involved if they have what's called the CERT program, the Community Emergency Response Teams, because oftentimes during disasters, people can't get to the emergency centers so that healthcare providers that can't get there can at least help within their communities and help act as leaders in the area.

Thank you.

Operator: Again, if you have a comment, please signal by pressing star-1.

We'll go next to Marcie Roth in Maryland.

Marcie Roth: Hi again.

I would strongly encourage that grant funds be available for independent living centers, protection and advocacy agencies, other community-based organizations and programs so that they are in a position to be able to assist people with some of the very complicated preparedness issues that people with disabilities face that are really more confounding because of their lack of access to the equipment and supplies that they need in order to be prepared.

And then as well in response and in recovery, those community-based service provider organizations run the risk of unfairly limiting resources to the rest of the community when they're providing a disproportionate amount of services to individuals who haven't been adequately assisted during a disaster and it then becomes much more of a community problem with organizations that have very limited resources.

So if there were grant funds that could support more emergency preparedness and response initiatives with a goal of keeping people from disproportionately using limited resources, I think it would be very wisely spent funding.

Operator: We will go next to Thomas Grace in Pennsylvania.

Thomas Grace: Yes, it's Tom Grace on the Delaware Valley Healthcare Council's behalf again.

Regarding the earlier suggestion around patient tracking systems and spreading that to other agencies, as far as the original question around funding sources or other grants, I'm aware that there are programs out and growing

interest in electronic health records and RHIOs, regional health information organizations.

If the emergency preparedness networking of patient tracking and patient information could be a subset of those different projects in the region levels, that may be a way to fund that. Patient tracking is still a significant need across much of the country.

Thank you.

Operator: We'll go next to (Cowika Feldman) in Pennsylvania.

(Cowika Feldman): Yes, a very simple request, a humble request that the hospital grants and grants that are available to hospitals to be relaxed a little bit, especially regarding vehicles.

We have surge capacity trailers, things like that, but we can't move them. So if that would be a consideration, that would be great, even to lease vehicles.

Thank you.

Operator: Again, if a you have a comment, please signal by pressing star-1.

We'll go next to Marcie Roth in Maryland.

Marcie Roth: Hi. I had one other idea that I'd like to suggest and that is that we really need to barcode durable medical equipment when people are at risk of being separated from their durable medical equipment and then Medicaid and Medicare are required to replace that equipment because it's been lost or

separated from the individual. It's just a real waste of Medicare and Medicaid funds.

Operator: At this time, there are no further comments.

Natalie Highsmith: Okay, so we can go ahead and move on to question number 5, which is are there innovative, economic ideas not considered that could be proposed from individuals on the call that would improve private healthcare facility emergency preparedness while not increasing healthcare costs?

Woman: With a special emphasis on mass casualty events.

Natalie Highsmith: We'll take comments on question 5.

Operator: We'll go first to (Paul Miller) in Louisiana.

(Paul Miller): Yes, and I'll go back to the transportation, especially dialysis facilities, even, you know, I can't comment on hospitals or other entities, but if we were allowed to provide our own transportation incentives, we could definitely get people out into safe areas quickly and be more responsive before that and prevent the bottlenecking that occurs with as mentioned previously by someone with special needs or persons who have special needs, these medical patients burden acute areas.

(Unintelligible) use that word, but as - from a global standpoint of response is that you don't want 5% of your population taking up all of your acute needs in hospitals in areas. These patients need to be getting out quickly and transportation, if we were allowed to do that, that would be the first thing.

And I'll mention that for those who are reviewing this is that the case (circular) like Ms. Wendy Schrag mentioned a while ago, we published two articles, several of us from that (unintelligible) in August and (unintelligible) 2007 that comments a lot about those specific recommendations, but specifically transportation, go to safe sites, and the water depots would allow better economic ability for our private industry to be able to contribute during mass disasters that we can't even imagine because Katrina would not have even been considered in my point, something like 100,000 crush injuries where we don't have enough critical care need beds in the United States to account for.

And thank you so much.

Woman: Thank you, sir.

Operator: We'll go next to (Scott Cormier) in Tennessee.

(Scott Cormier): Yes, if you could consider giving incentives to hospitals that meet certain preparedness standards similar to the value-based purchasing program where when all of those things are being considered that there could be some extra percentages of reimbursement based upon their preparedness.

Thank you.

Operator: We'll go next to (Patrick Cochlea) in DC.

(Patrick Cochlea): Yes, this is (Patrick Cochlea) from the Office of (Disability Employment) Policy, Department of Labor.

What I would suggest would be a - the private healthcare facilities also working in coalitions with, you know, local stakeholders and all of the people that need to come to the table for people with disabilities, especially as it concerns emergency preparedness.

We've seen some success with that with our own committees at the federal level with even being able to provide additional sort of assistance in information response for the California wildfires as well.

And creating that economically also creates a long-lasting relationship with all sorts of stakeholders that when the emergency does actually come to your door, you already have a lasting relationship with the people that you're going to need assistance from.

Operator: We'll go next to Rich Kaiser in North Carolina.

Rich Kaiser: Yeah, hi. It's Rich Kaiser, President of SoftDev, Incorporated.

When we volunteered and installed a wireless network after Hurricane Katrina, it wasn't our network. We went down there and helped with what was already there. And the one thing that struck is it was a really large area that had suffered.

And, of course, it was compounded by the amount of vehicles on the road, traffic, total lack of communications for three weeks and the lack of cables for four.

So the point of it all was that there was so much ad hoc, so many people winging it, so many people just picking up with what they had and trying to

move forward and help people that it was striking how centralized systems don't work.

So I realize that most of the issues that are going to be faced by a typical society are going to be what large facilities are talking about. They need, you know, caches of, you know, storage for materials and help.

But what I actually saw in Biloxi, Mississippi was a scramble. And if a hospital (that's) two miles away had every supply in the world, it wouldn't've mattered because nobody knew. And everyone was scrambling trying to either get out of the way or get in the way. I don't know what the heck was going on down there.

But the one thing I did notice was a lot of people cried when we put in the wireless Internet because there was something about being able to actually talk to other people. And they started calling out and telling family members that they were okay.

But the point of it was that they did it not through a centralized system. They didn't use the phone company. They didn't - you know, there was no billing systems involved. There was no forms to fill out. We - sometimes we just hung phones on a board and let - walked away, let people use them.

These ad-hoc systems work in a mass casualty because you can not rely on anything else. They really do work because they don't - they aren't based on the premise that something works. You know, these are very easy to come up with any situation and then apply them.

And the one thing I always said that if the big wave came along and took everything with it, we could replace the network, go to the store and get new ones and have it replaced quicker than anything.

So my whole point was that facilities, if they want to take disaster recovery and emergency response seriously, they need to have their own ability to communicate.

And any facility that's reliant on the phone company or on the cable company is somewhat not as well prepared if they have even a walkie-talkie because in a terrible disaster, a walkie-talkie might give them information from across the street while these other systems aren't going to help them at all.

That's what we saw in Biloxi that, you know, injecting communications seemed to fix a lot of things. It was like clearing out a logjam because things started flowing.

And I just wanted to emphasize to facilities that if they really want to have the capability to be on their feet after whatever happens, they're going to need to be able to communicate, ask for help, or offer help to someone else. And to do that, they're going to need wireless Internet because that's the current technology that's being used.

And then somebody mentioned satellite earlier. And in Biloxi, the Skytel guys used to - they laughed when we showed up because they could pack up their stuff and stop trying to do what they were trying to do, which wasn't working. They were setting up satellite communications in the clouds. And clouds apparently got in the way.

So the Skytel guys, they pretty much liked it that we were coming in behind them because they didn't care much about how - you know, they were scrambling themselves.

All they cared about is that the people were able to communicate. And they didn't care if it was Skytel or us. So when we showed up, it made their job easier, too.

So I don't know how to emphasize it enough because it's one of those issues that's not being brought up. I read the President's report, which was, "Lessons learned." I read the congressional report, which was titled something else.

And both of them mentioned ham radio operators as being the only way to communicate in Hurricane Katrina. And I thought that was odd because the only way to communicate more than one person to one person was wireless Internet.

And everybody knew that. I know the name of the company that's still down there and I know the name of all of the facilities and the resources. And we were even setting up campgrounds so that the relief workers could call home.

And I don't know exactly why it would be neglected. It's wireless Internet. Why is it not a pertinent issue? But I really - even at my own hospitals, if they don't have any antenna, I find another hospital because I they're not really serious about healthcare if they don't have the basic ability to communicate on their own.

Thank you.

Natalie Highsmith: Thank you, Mr. Kaiser. Next comment, please.

Operator: We'll go next to Wendy Schrag in Kansas.

Wendy Schrag: Oh, I think several people have already mentioned this, but again, just want to highlight the importance of community coalitions. I think a lot of times we do a good job of having maybe national coalitions within our own industry, but getting down to the community level, I would really like to see health departments, state and county, start organizing emergency preparedness community coalitions.

Operator: We'll go next to (Lowell Feldman). I'd like to remind participants, if you have a comment, please signal by pressing star-1.

Mr. (Feldman)...

(Lowell Feldman): Yes.

Operator: ...please go ahead.

(Lowell Feldman): Yes, thank you.

I'd like to reemphasize under this question the importance of training for disaster preparedness. Especially workers, healthcare workers in long-term care aren't in emergency rooms and I think via distance learning and mobile learning by certain qualified experts in the industry, it's necessary to really get people prepared.

I know in the Northeast, Stony Brook University has (unintelligible) distance learning program, which loves grant funding. And Adelphi University I think

has one of the best master's programs going in emergency nursing, which has to get on the road.

It has to get out there to the facilities to learn how to set up triages, to learn who to treat and who to refer to other sources. And I think that's probably the most important thing is the education of how to deal with the disasters.

Thank you.

Operator: Again, if you have a comment, please signal by pressing star-1.

We'll go to Marcie Roth in Maryland.

Marcie Roth: Hi, it's Marcie Roth again.

Piggybacking on the education comment, I wholeheartedly agree. And it's critically important that all education initiatives include experts on disability and emergency management. It's not enough to have expertise in emergency management. It's not enough to have expertise in medical - in the myriad of medical care professions.

It's critically important that education include experts with disabilities, experts who are knowledgeable about the additional needs of people with disabilities.

One of the reasons that there's so much pushback around the term "special needs" is because in an emergency or in a disaster, special becomes second tier.

Special becomes when you're triaging what you deal with after you've dealt with mass care. And so people with disabilities are especially concerned about

being considered special because special could mean that they don't get the same access as everybody else.

So two points, one is we need to be cognizant that when we're thinking about the needs of people with disabilities that we don't think of them as special, and two, we need to make sure that we have experts on disability involved in all education and all decision-making across the board.

Thanks.

Operator: If anyone has a comment, please press star-1.

We'll go next to (Paul Miller) in Louisiana.

(Paul Miller): I'm going to mention two things, and I guess the last comment about the special or special needs designation is that it's a concern for those of us who provide so much care to patients who are required extra needs is to get them out of the disaster area. There has to be a way of designating them so that they do receive the appropriate care. And I agree with the specialized training.

The second comment is that in all of these efforts that we try to identify, whether it be by special radio tags or whatever of these patients who go to shelters and go to areas, we've got to have a better mechanism of reporting communicable or transmittable diseases, whether it be MRSA, MRSE, VRE, or other infections that we know we report in chronic situations -- that is nursing homes and/or dialysis units, et cetera, or hospitals when they're transporting to other areas to prevent the vector spread.

There should be a better mechanism to help prevent this, universal precautions that breaks down during disasters that we haven't even tracked to the CDC.

And we've asked about hepatitis transmission and infections where we see such a growth where people evacuated out of Katrina areas and went all over, what kind of damage and vector spread. And that's a concern of ours.

And again, you know, the disaster preparations have been wonderful. The (KSERC), wonderful efforts by a lot of different groups. It would be nice to have cross-collaboration and communication so we can assist each other in various similar circumstances.

And thank you so much (unintelligible).

Natalie Highsmith: Thank you.

We have time for one final comment on question 5.

Operator: We'll go next to (Elaine Barav) in Florida.

(Elain Barav): Good afternoon. It's (Elain Barav).

And I am a member of a home healthcare agency, for profit, and as such, our organization, Associated Home Health Industries of Florida, has a subcommittee, of which I am a part, and it has to do with mutual aid. I guess you could call it a mutual aid society.

We have a plan, which we have been fortunate enough to get backing for, and to roll it out to the members of our association, which will allow them to help each other in time of need.

And it certainly would address point number one, federal budget neutrality, because it is community helping community, as one of our previous answerers said.

So it does work. I heard about the buddy system here. And it certainly does work because we are looking to place similar home health agencies with similar others in the area to provide both personnel if needed, but more importantly, the supplies and a place to work, meaning computer access and housing.

Thank you.

Natalie Highsmith: Okay. Thank you for that comment.

Now Dr. (Fitzgerald) has a question that he would like to pose to our listeners.

(Dennis Fitzgerald): How're you doing? (Dennis Fitzgerald). I'm a physician in charge of working group for Paragraph 30 for the HSPD 21. And in the remaining time that we have on this call, we just wanted to get a little sense of some of your responses to perhaps some of the issues that we're dealing with.

And the specific question I have for you all is the following -- what legal or regulatory barriers to public health and medical preparedness and response from federal, state, or local governments or even private sector sources can be effectively eliminated by appropriate regulatory or legislative action?

That's the basic question we're wrestling with. What I'll - what I will share with you is basically how we've constructed the collection of responses for that.

What we're trying to do is frame it in terms of really five big themes. The first theme is barriers that impede healthcare professionals from delivering care in a disaster. The second theme is barriers that impede effective access to healthcare and human services in a disaster. The third theme is barriers to stockpile procurement and mass prophylaxis distribution. The fourth theme is barriers that impede effective quarantine and social distancing measures. And finally, the fifth theme involved limitations to funding, resources, and logistics delivery of relief during a disaster.

So what we're trying to get to are specific issues that may fall under one of those kind of key themes and would appreciate any feedback you might have on this question for us.

Woman: (Unintelligible).

Operator: We will go to Marcie Roth in Maryland.

Marcie Roth: I don't know what the issue with - what the regulatory issue is, but the Red Cross seems to think that there is a liability issue in meeting the additional healthcare needs of people with disabilities in Red Cross shelters that is somehow a different level of liability than the other liability that they take on in their shelters.

And we can't ever quite seem to tease out what that, but it's certainly a barrier. And if there is some sort of regulatory fix or if there's some mechanism that will address liability issues, I think that that will have a tremendous effect across the board in making those mass shelters - mass care shelters more able to open their doors to people who can then not be in those med/surg environments.

(Dennis Fitzgerald): Okay, thank you very much.

Operator: We'll go to (Paul Miller) in Louisiana.

(Paul Miller): Yes, Dr. Fitzgerald, specifically the quarantine issue that I mentioned earlier that there's got to be a better way for us to prevent vector-spread infections in congregated areas.

We worry more about meningitis in military or grouping areas, but we don't worry about that during disasters. And I know it's impossible to fix everything, but especially patients that come in through (EORS) hospitals that are chronically infected patients, not just the CDC standards of do they have incontinence with VRE or some obviously visible drainage site, there's got to some - better clarified guidelines for all institutions.

As for as your stockpile question, you know, it's not going to be perfect as far when anytime you have a request mechanism going through your local EOC, local government, and then requesting it through the assets of the federal government, the barriers, policy issues, I think it's wonderful the (KSERC) has done this through Dr. (Jeffrey Copp) to form a volunteer service that would be federalized program for specific people and maybe address one of the other questions about having specialized persons, like we have in dialysis specialized personnel that take care of special patients, then the barriers policy is that unless you are federalized, you will not be able to access care or provide care in those federalized areas of emergency.

And I would say that as a result of that, access to health is very limited if those who direct patients in that tiered process of triage, treat, and transport, who direct them to areas if they're not familiar with the local schemes.

We saw that a lot in Katrina, post-Katrina, is that the communication of the federal assets of the local and other assets were not coordinated well enough so that access to care was limited, was delayed, and was bottlenecking acute areas by holding on to patients in the local shelters too long that could not provide services for. And that has been a limitation. Focusing on transportation would be the biggest issue.

And thank you so much, Dr. (Fitzgerald).

(Dennis Fitzgerald): Thank you very much.

Operator: We'll go next to Janice (Zales) in DC.

Janice Zalen: Thank you.

I am not sure which theme it falls under, but I do think appropriate legislative action is needed to change the Stafford Act, which was talked about earlier in this phone call, to allow for-profits as well as the not-for-profit healthcare facilities to be able to access disaster preparedness funds.

And I think that that would also be true for many other grants, a need to change the legislation so that not for - so that for-profits would also be eligible.

Thank you.

(Dennis Fitzgerald): Thank you very much.

Operator: Next we'll go to Rachel Hammon in Texas.

Rachel Hammon: Well, I guess for the first two questions, barriers that impede professionals delivering care and then barriers to access to services, I would say the Survey and Certification Division should really look at what the regulations are and preparing policies ahead of time for loosening of those regulations during a disaster so that professionals can provide care, especially out in the community.

For instance, when we had a surge of individuals through hurricane - both Hurricanes Katrina and Rita of displaced individuals in the community, you know, home health agencies were, you know, closed or people were moving out of the area.

Other home health agencies were experiencing massive surges of people coming into their communities. And there was a real need for immediate regulatory relief so that they could provide those services without fear of not getting their reimbursement or, you know, or those agencies who were closed or had to move their locations of being later shut down because they were out of compliance with serving clients in their community or outside of their designated community.

So I think in terms of looking at regulatory relief and professionals providing care that really should be done ahead of time. And then also to reiterate some things that were said earlier about special needs shelters and the other shelters, allowing different levels of providers into those areas from the community in order to provide care and handle the surge of people in those areas.

(Dennis Fitzgerald): Great. Thank you.

Operator: We'll go next to (Lowell Feldman) in New York.

(Lowell Feldman): Yes, I'd like to bring up one issue that I don't believe has been brought up yet and that would be (unintelligible) and that has to do with sometimes frivolous and sometimes not malpractice claims during disasters.

We've seen many instances where, you know, in hindsight there were lawsuits leading to not only civil, but criminal for decision-making process (unintelligible) disasters and in many cases unjustified.

And I think there needs to be some regulation and legislation preventing such lawsuits from occurring while in disaster situations and medical providers are trying to do their best, often without the best working environment, supplies, and really to protect the industry, individuals and organizations, from the aftermath of a lot of negative outcomes.

Thank you.

(Dennis Fitzgerald): Thank you very much.

Operator: Next is Jocelyn Montgomery from California.

Jocelyn Montgomery: Yeah, to build on what (Noel) just said, I believe there are protections for individuals who join as medical volunteers, but there's no protections for the facilities that accept them.

So in thinking about nursing homes and other long-term care facilities, if I develop a policy that allows me to utilize those volunteers during an event, I'm completely by the seat of my pants.

So I think legislatively there needs to be at least a discussion about the use of volunteers in healthcare facilities. I'm not aware of any regulations under Survey and Certification that address this.

And I think that would be a beginning. At least if there was guidance for facilities on what the standards are for credentialing these people and allowing them to come in and provide care, that would at least begin to address the issue of liability for facilities.

There also needs to be a provision for reimbursement for stockpiling of supplies. In California, I know our facilities - nursing home facilities are expected in many communities to at least hold on to their own residents in a pandemic influenza and at most to be part of the surge planning in that they would receive people, potentially infectious people.

They don't have any money and they're not part of the - as far as I know the public health stockpile planning for personal protective equipment, Tamiflu, or, you know, other kinds of agents that hospitals are already in many communities really well stocked on those things, but we have no provision for reimbursement. So that's a limitation to funding.

And then I think the things that we talked about before in terms of having emergency admit policies that are legislatively described that will allow us to have these mutual aid agreements and act as receiving sites for each other would really help in a wide-scale event.

(Dennis Fitzgerald): Terrific. Thank you.

Operator: We'll go next to Rich Kaiser in North Carolina.

Rich Kaiser: Hi, Rich Kaiser, President of SoftDev. Two things I just wanted to point out that there should be a preemptive characteristic to disaster preparation so that like the sister facility or buddy program.

I really thought, you know, I was just emotionally upset because a month after a disaster is not a - not the time to find out that nobody's asked. So there should certainly be a facility or a faculty in place to where if some nursing home is unable to scream for help, that there is actually a program where somebody will go ask them.

And since I was the first one to do it and it was a month after the storm, it was pretty disturbing. And I just think that there has to be some basic change to the way disaster and emergency processes are changed so that they actually handle the situations that people are in.

The whole idea of requesting for help works wonderfully until people are unable to scream. And then it seems like things break down pretty quickly.

The second thing was that the - as people mentioned earlier, (unintelligible) getting crash carts and centralized storage things, I don't think there's enough money in the world to prepare for every disaster, so I would certainly think that the healthcare facilities need to organize and start networking together so that if resources are, you know, available, they become available to everyone.

And it doesn't make sense for everybody to handle everything because in an emergency, it'll be very unique and individual circumstances. And the best thing that'll handle the emergency is if everyone is able to deal with it.

Everything short of that is individual effort, so I just think that it'd be a lot more cost-saving if people organized their resources and, you know, cut down

on the number of purchases, but wound up with a more effective delivery of service.

Thank you.

Operator: We'll go next to (Robert Jaysic) in DC.

(Robert Jaysic): Yeah, this is (Bob Jaysic). I'm with the American Association of Orthopedic Surgeons. And I just wanted to echo the importance of the first theme about professionals being able to deliver care.

And we've been trying to proactively educate our members to - on the process for participating and being available in the event of an emergency. But what we found with a lot of our members is significant barriers in terms of getting certified and variances from place to place in the ability to do that.

So whatever can be done to sort of streamline that and whether it's, you know, streamlining, you know, participation in VA programs and that allowing you to participate would be extremely beneficial because a lot of ours, it's just taking them years and years to get everything done. And that's with people who are trying to be proactive, not even last minute about it.

So we'd be happy to help in whatever way we can with that first piece.

Natalie Highsmith: Okay, (Lori), we have time for one more comment on the questions that...

(Dennis Fitzgerald): We'll go to (Fran Stafford) in Ohio.

(Fran Stafford): Yes, in order for long-term care facilities to be able to participate in any type of a surge or to admit emergency patients that may be disabled being provided

care at home but due to the lack of supplies need to come in temporarily, we would need a relaxation of the regs in regards to (Path R) and three-day stays in hospitals.

The other thing in order to be able to accommodate a surge like that, there would also have to be a relaxation of when (MDS)s and those type of assessments are submitted because we would not have the staffing if we were admitting significant numbers to get those things done within five days.

(Dennis Fitzgerald): Thank you very much.

Natalie Highsmith: Okay, now we will have Peggy Sparr for her closing remarks.

Peggy Sparr: Thank you all very much for your participation today. We really appreciate the creativity and the thoughts and also the best experiences in - that you've all had as a result of your experiences in doing emergency preparedness to date and specific problems that you've experienced during our work in prior disasters.

If you were not able to be reached today for your comments, we would ask you to please forward additional comments or information or other suggestions to - we listed the mailbox. It is at the bottom of the agenda.

But I'll say it again on the call. It's H as in Harry, S as in Sam, P as in Paul, D as in dog, 21 dash 40 underscore N as in Nancy, D as in dog, M as in Mary, S as in Sam at hhs.gov. Okay?

And as previously stated by Dr. Davis, a transcript of this Open Door Forum will be an attachment to any document that is forwarded to the White House.

The information and ideas from the Open Door will be used to develop questions for additional focus groups that may be yet convened.

A copy of the transcript can be made available through a web link that is - we're going to put this...

Woman: (Unintelligible).

Peggy Sparr: ...you can say this.

Natalie Highsmith: The transcript along with the audio file...

Peggy Sparr: Correct.

Natalie Highsmith: ...will be posted on the Special Open Door web site after March 20.

Peggy Sparr: I'm sorry. Yes, thank you.

And thank you all for your participation. And even if not adopted, your ideas will certainly stimulate thinking and contribute to better preparing the nation for handling a mass casualty event.

Natalie Highsmith: (Lori), can you tell us how many people joined us on the phone lines?

Operator: Today we had approximately 273 participants.

Natalie Highsmith: Two seventy-three, wonderful. Thank you all and remember to submit your comments to the email box that Peggy just said.

And also the materials will be posted on the Special Open Door web site for 30 days, as well as the audio link and the transcript.

Thank you.

Operator: Thank you very much, ladies and gentlemen, for joining today's conference. This does conclude your call. You may now disconnect.

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