

Engaging Healthcare Partners in the Disaster Healthcare Delivery System



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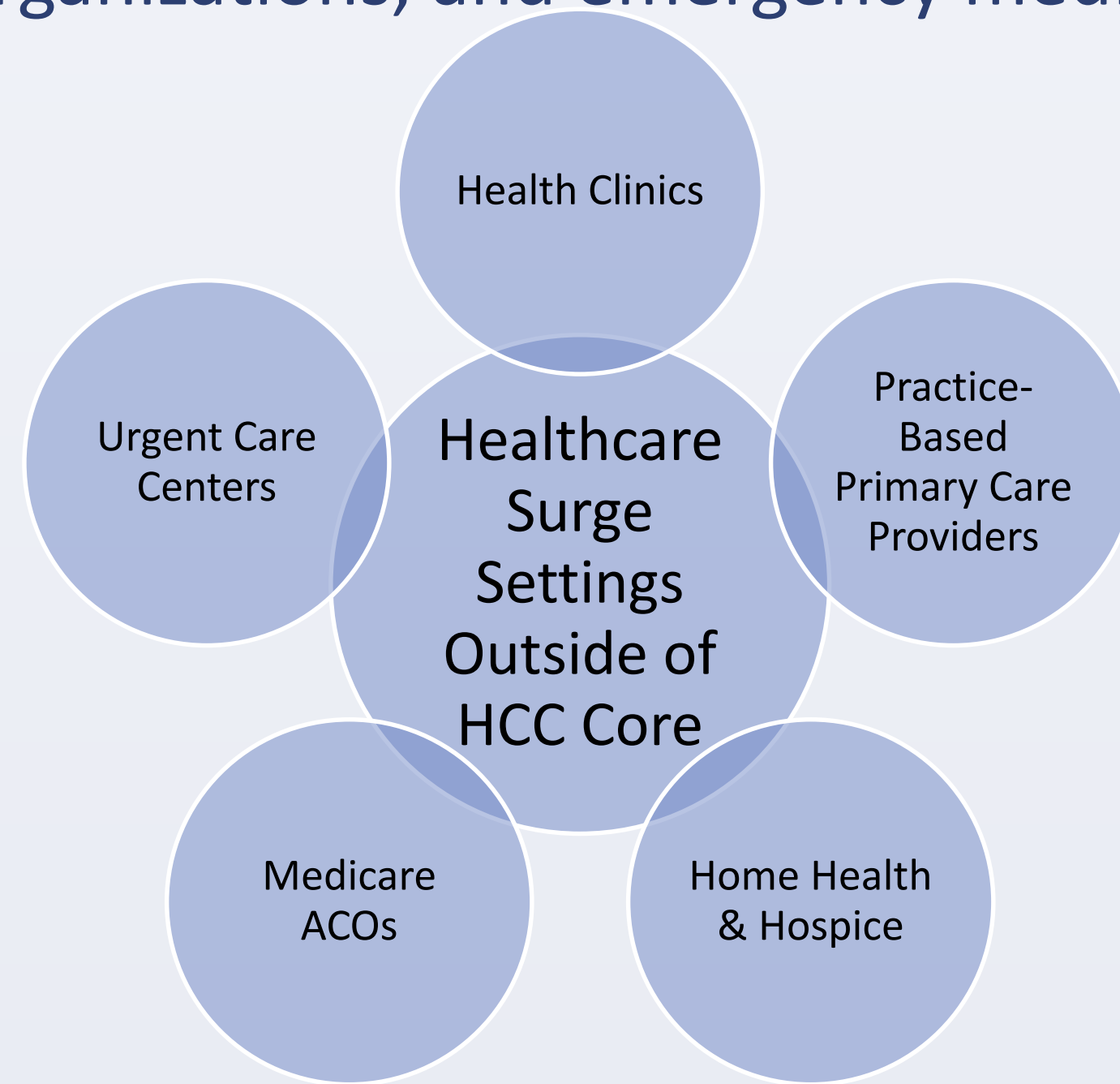
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INTRODUCTION



The U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response (ASPR)'s Hospital Preparedness Program supports the development of regional healthcare coalitions (HCCs). The core members of HCCs are hospitals, public health departments, emergency management organizations, and emergency medical services.



In 2017, ASPR's Technical Resources, Assistance Center, and Information Exchange (TRACIE) began exploring the role of healthcare settings outside of the core HCC members in healthcare system surge response, including:

Health Clinics

- 1,400 Federally Qualified Health Centers (FQHC)
- 4,100 Rural Health Clinics (RHC)
- 1,200 Free & Charitable Clinics

Urgent Care Centers

- Nearly 8,800 clinics

Primary Care Providers

- Approximately 300,000 primary care physicians
- Additional nurse practitioners & physician assistants

Home Health Care & Hospice

- Nearly 12,500 home health agencies
- 4,000 hospices

Accountable Care Organizations (ACO)

- Medicare Shared Savings Program (MSSP)
- Next Generation

Health clinics play a pivotal role providing primary care and preventive health services to the nation's most vulnerable populations, including those in medically underserved areas.

Urgent care centers offer care for acute but non-life-threatening illnesses and injuries in convenient locations during extended hours.

Primary care practices have expertise in treating specific populations, such as children and older adults.

While each care setting varies in size, offered services, and areas of specialization, all are capable of providing at least a basic level of healthcare services and are located in every corner of the country.

ASPR TRACIE sought to learn whether these settings saw a role for themselves in emergency preparedness and response and, if so, what those activities are.

METHODS

Completed projects focused on health clinics, urgent care centers, and practice-based primary care providers.

Health Clinics

- Recruitment via National Association of Community Health Centers (NACHC), state primary care agencies (PCA) & governmental partners
- Convenience sample of individuals serving in leadership positions
- 175 online survey responses & 25 follow-up interviews
- Represented 38 states in all 10 HHS regions

Urgent Care

- Recruitment via Urgent Care Association of America (UCAOA) & American Academy of Urgent Care Medicine (AAUCM)
- Convenience sample of urgent care center leaders
- 18 telephone interviews
- Represented centers in 44 states & 1 territory

Primary Care Providers

- Interviews with representatives of: American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American Academy of Physician Assistants (AAPA), American Association of Nurse Practitioners (AANP), American College of Physicians (ACP), and American Geriatrics Society (AGS)

Survey and interview topics included: the role of each healthcare setting in both infectious disease and no-notice incident scenarios; level of capability and infrastructure for response; characteristics of preparedness activities; status of business continuity efforts; and factors that facilitate engagement in emergency management activities.

Online surveys and follow-up one-on-one telephone interviews with home health care and hospice agencies on similar topics are complete; data analysis is ongoing with results expected in late spring 2019. Data collection through online surveys and follow-up interviews with MSSP and Next Generation ACOs will be complete in summer 2019.

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RESULTS

- Regardless of the healthcare setting, **most survey and interview respondents perceive a role for their setting in community emergency preparedness and response efforts.** The extent to which they reported they could expand their existing infrastructure and services during an incident is dependent on the scenario and its effect on their facilities and staff.
- **Commonly reported capabilities include:** treating low-acuity patients, patient triage, patient risk communication, expertise in treating vulnerable populations, temporary treatment site or safe haven, behavioral health support, responder health support, public health surveillance/ patient monitoring, and support for vaccination or mass dispensing efforts.
- **Most test their ability to implement various emergency procedures and protocols** through preparedness exercises or real-life incidents. Some test scenarios based on formal or informal risk assessments while others limit their experience to activities required by state or federal regulators or their parent healthcare system, if they are part of such a system. Scenarios tested include electrical outage, active shooter, bomb threat, fire, severe weather, earthquake, pandemic, and mass dispensing.
- A **major challenge to preparedness** is lack of time to participate due to the focus on patient care activities. **Identified obstacles and challenges to involvement in response** include: limited trained staff, available facilities and equipment may not meet needs, challenges in obtaining and storing supplies, and difficulty accessing the care site.
- Among those less engaged in emergency management activities, **the greatest motivator to participation is being asked.** This could be in response to patients seeking care or at the request of an HCC, healthcare system partner, or local, state, or federal public health or emergency management agency.
- FQHCs and RHCs required to comply with the **Centers for Medicare and Medicaid Services (CMS) Emergency Preparedness Final Rule** report widespread awareness of the newly implemented requirements, but the level of knowledge about how to implement specific aspects of the Final Rule varies. Inclusion in community drills/exercises and targeted education/training on requirements for these settings were identified as factors that would enable their successful compliance.

DISCUSSION

- Healthcare settings outside of the core HCC members have capabilities in preventive care and disease management services that can make communities more prepared and resilient; can treat lower acuity patients to help decompress hospital emergency departments during surge responses; and can provide follow-up care and monitoring during the disaster recovery phase.
- They also have begun implementing business continuity strategies to enable sustained care of existing patients and potential care of new patients whose normal care settings have been disrupted by an emergency.
- Wide variation exists in the capacity and resources of individual practice settings and the potential healthcare surge role of these non-HCC core partners has not been clearly defined in most communities.

ASPR TRACIE identified the following actions to improve the readiness of healthcare settings outside of the core HCC members for emergencies and disasters:

- Better define the role of each setting in overall community emergency management efforts.
- Increase engagement of each setting with HCCs and other community partners.
- Provide training, technical assistance, and other resources to support emergency management knowledge and activities.
- Promote opportunities for knowledge exchange and learning, particularly highlighting the lessons learned of those with emergency response experience.
- Encourage the use of hazard vulnerability analyses to establish emergency response expectations based on capabilities and community threats.
- Promote continuity of operations planning to aid in resilience efforts.
- Support FQHCs, RHCs, home health, and hospice settings in implementing their CMS Final Rule requirements.

ADDITIONAL INFORMATION

Related ASPR TRACIE resources:

- Medical Surge and the Role of Health Clinics (Report, Summary, and Q&As)
- Medical Surge and the Role of Urgent Care Centers (Report, Summary, and Q&As)
- Medical Surge and the Role of Practice-Based Primary Care Providers (Summary with Q&A)
- To be completed in 2019: home health and hospice and ACO projects



To request more information, contact:
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