

ASPR TRACIE Technical Assistance

On January 11, 2017 ASPR TRACIE supported a webinar hosted by the ASPR National Healthcare Preparedness Program (NHPP) titled, *Learning More About the 2017-2022 Health Care Preparedness and Response Capabilities*. This webinar: provided an overview of the background and intent of the capabilities; shared how the capabilities have evolved over time; provided an overview of each capability and how they are applicable; and provided an overview of challenges and next steps. The PowerPoint presentation and recording of the webinar are available at: <https://asprtracie.hhs.gov/documents/aspr-tracie-hcc-webinar-hpp-capabilities.pdf>.

Due to the large number of questions received during the Question and Answer (Q&A) portion, we were unable to present and have speakers respond to all of the questions during the webinar. Questions that were not able to be answered during the webinar due to time constraints were answered via email. Below are the answers provided to participants after the webinar.

Q&A:

1. Can you give examples of what group or groups of the population are a part of a RNHCI?

Answer: ASPR TRACIE has developed a CMS Emergency Preparedness (EP) Rule Resources at Your Fingertips Document and within this document, we reference a definitions document we have on Provider and Supplier Types Covered by the CMS Emergency Preparedness Rule. Page 7 of this definitions document provides the following description of Religious Nonmedical Health Care Institutions (RNHCIs):

CMS defines RNHCIs as tax-exempted religious organizations that provide nonmedical nursing items and services to beneficiaries who choose to rely solely upon a religious method of healing, and for whom the acceptance of medical services would be inconsistent with their religious beliefs. RNHCIs furnish nonmedical items and services exclusively through nonmedical nursing personnel who are experienced in caring for the physical needs of nonmedical patients (e.g., assistance with activities of daily living; assistance in moving, positioning, and ambulation, nutritional needs and comfort and support measures). They also furnish nonmedical items and services to inpatients on a 24-hour basis. They do not furnish patients, on the basis of religious beliefs, through its personnel or otherwise, medical items and services (including any medical screening, examination, diagnosis, prognosis, treatment, or the administration of drugs).

For more information: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/RNHCIs.html>

2. Are there any specific guidelines related to Medical or mental response via Telemedicine?

Answer: The 2017-2022 Health Care Capabilities document references telemedicine for Telemedicine/virtual medicine for alternate care sites and perhaps this can also be utilized as adjunct method for other medical response.

- Use telephone, internet, telemedicine consultations, or other virtual platforms to provide consultation between providers

- Provide access to specialty care expertise where it does not exist within the HCC to allow for remote triage and initial patient stabilization
- Establish call centers to offer scripted patient support

There are no specific guidelines on how to use telemedicine but ASPR TRACIE has developed a [Virtual Medicine Topic Collection](#) with resources that may be helpful.

3. Children represent 25% of the population. How can we ensure that appropriate preparedness, response and recovery specific to pediatrics is provided through the coalition structure and funded appropriately?

Answer: Each HCC should promote its members' planning for pediatric medical emergencies and foster relationships and initiatives with emergency departments that are able to stabilize and manage pediatric medical emergencies. HPP awardees and the EMSC program awardees within their jurisdictions must provide a joint letter of support indicating that EMSC and HPP are linked at the awardee level. HPP awardees must provide the initial letter of support with their funding applications at the beginning of each budget period throughout the five-year project period. HPP awardees must work with HCCs and EMSC to ensure that all hospitals are prepared to receive, stabilize, and manage pediatric patients.

At the end of each budget period, HRSA will provide HPP with data regarding each hospital's capability to manage pediatric medical emergencies to assist with this work. All hospitals should be prepared to receive, stabilize, and manage pediatric patients. However, given the limited number of pediatric specialty hospitals, an emergency affecting large numbers of children may require HCC and ESF-8 lead agency involvement to ensure those children who can most benefit from pediatric specialty services receive priority for transfer. Additionally, pediatric practitioners may be able to help identify patients who are appropriate for transfer to non-pediatric facilities. EMS resources, including providers with appropriate training and equipment, should be prepared to transport pediatric patients.

The HCC should promote its members' planning for pediatric medical emergencies and foster relationships and initiatives with emergency departments that are able to stabilize and/or manage pediatric medical emergencies. Specialty referral centers such as pediatric centers may also serve as referral centers to other HCC's where that specialty care does not exist. In such cases, referral centers' support of HCC planning, exercises, and response activities can be mutually beneficial.

4. Will the new grant allow for utilizing funds for deploying/response?

Answer: Temporary Reassignment of State and Local Personnel during a Public Health Emergency Section 201 of the Pandemic and All-Hazards Preparedness Reauthorization Act of 2013 (PAHPRA), Public Law 113-5 amends section 319 of the Public Health Service (PHS) Act to provide the Secretary of the Department of Health and Human Services (HHS) with discretion to authorize the temporary reassignment of state, tribal, and local personnel during a declared federal public health emergency upon request by a

state or tribal organization. The temporary reassignment provision is applicable to state, tribal, and local public health department or agency personnel whose positions are funded, in full or part, under PHS programs and allows such personnel to immediately respond to the public health emergency in the affected jurisdiction. Funds provided under the award may be used to support personnel who are temporarily reassigned in accordance with section 319(e). This authority terminates September 30, 2018. Please see detailed information available on the ASPR website at <http://www.phe.gov/Preparedness/legal/pahpa/section201/Pages/default.aspx>

Under certain conditions, HPP funds may, on a limited, case-by-case basis, be reallocated to support response activities to the extent they are used for purposes provided for in Section 319C-2 of the PHS Act (the program’s authorizing statute), applicable cost principles, the funding opportunity announcement, and the awardee’s application (including the jurisdiction’s all-hazards plan). Awardees should contact their assigned HPP project officer and grants management specialists for guidance on the process to make such a change. ASPR encourages awardees to develop criteria such as costs versus benefits for determining when to request a “scope-of-work” change to use a real incident as a required exercise.

The request to use an actual response as a required exercise and to pay salaries with HPP funds for up to 7 days will be considered for approval under these conditions:

- A state or local declaration of an emergency, disaster, or public health emergency is in effect.
- No other funds are available for the cost.
- The awardee agrees to submit within 60 days (of the conclusion of the disaster or public health emergency) an after-action report, a corrective action plan, and other documentation that supports the actual dollar amount spent.

Note: A change in the scope-of-work is required to use an actual event as an exercise whether or not funds are needed to support salaries. Also, regardless of the amount of money used in response to an event, the State is still required to meet all the requirements of the original award.

5. Why are vehicles not allowed? We have tremendous assets in trailers, but moving them during a response is always difficult.

Answer: HPP Vehicle Purchase:

- Non-public road vehicles: HPP grant funds can (with prior approval) be used to purchase health care coalition material-handling equipment (MHE) such as industrial or warehouse-use trucks to be used to move health care coalition materials, supplies and equipment (such as forklifts, lift trucks, turret trucks, etc.). Vehicles must be of a type not licensed to travel on public roads.

HPP Vehicle Leasing and Hauling Agreement, Passenger road vehicles:

- HPP grant funds cannot be used to purchase over-the road passenger vehicles.

- HPP grant funds can (with prior approval) be used to procure leased or rental vehicles as means of transportation for carrying people (e.g., passenger cars or trucks) during times of need. Examples include transporting health care coalition leadership to planning meetings, to an exercise, or during a response.
6. Is it acceptable for a State to identify the existing Health and Medical emergency preparedness (i.e. ESF-8) workgroups and related mutual aid groups that are linked by robust communication networks as its Healthcare Coalitions for purposes of the HPP?

Answer: Those linked by communication networks are a great starting point, but the day-to-day delivery patterns should either match those communications networks or be synched.

7. How can home health agencies help coalitions understand the importance they play and that there has been no funding in the past for home health agencies to prepare for emergencies and are starting at the beginning where funding is involved?

Answer: Resilient communities develop, maintain, and leverage collaborative relationships among government, community organizations, and other health care entities to more effectively respond to and recover from disasters and emergencies. ASPR defines an HCC member as an entity within the HCC's defined boundaries that contributes to HCC strategic planning, identification of gaps and mitigation strategies, operational planning and response, information sharing, and resource coordination and management. HCCs must collaborate with a variety of stakeholders to ensure the community has the necessary medical equipment and supplies, real-time information, communication systems, and trained and educated health care personnel to respond to an emergency. Home health agencies that become members of the HCC are encouraged to promote the value of the partnership.

Additionally, the Centers for Medicare & Medicaid Services (CMS) issued the Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers Final Rule to establish consistent emergency preparedness requirements for healthcare providers participating in Medicare and Medicaid, increase patient safety during emergencies, and establish a more coordinated response to natural and human-caused disasters.

This rule applies to 17 provider and supplier types (including home health) as a condition of participation for CMS. In the ASPR TRACIE developed document, [CMS Emergency Preparedness \(EP\) Rule Resources at Your Fingertips Document](#), we include a section for Healthcare Coalitions seeking additional information for how to engage these provider and supplier types. Additionally, ASPR TRACIE has developed a Topic Collection focused on [home health agencies](#) which provides plans, tools, and other resources to help in their preparedness and response efforts.

8. You mentioned Health system concurrence. Is that stated in the application for this budget period?

Answer: Awardees may retain direct costs for the management and monitoring of the HPP cooperative agreement during the 2017-2022 project period. Awardee-level direct costs are defined as personnel, fringe benefits, and travel. Because the goal is to support HCCs and their health care system partners, awardees must limit these direct costs to no more than 18 percent of the HPP cooperative agreement award. By the end of Budget Period 5, awardees must limit these direct costs to no more than 15 percent of the HPP cooperative agreement award.

ASPR will consider requests for exemptions on a case-by-case basis. Requests for exemptions will be strengthened by letters of support from the HCCs and the jurisdiction's hospital association, indicating these entities understands and agrees with the amount the awardee is retaining for awardee-level direct costs. Please note that concurrence is not required, only recommended if an awardee is requesting an exemption.

9. Compared to the National Preparedness Goal Core Capabilities, these capabilities, aside from MedSurge, are very broad and cover a variety of activities. Was there any consideration toward structuring these more similarly to the Core Capabilities with mission areas and more specific capabilities?

Answer: The Emergency Preparedness Grant Coordination Working Group developed an interim capability crosswalk of the 2015 National Preparedness Goal core capabilities, 2012 Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness, and the 2011 Public Health Public Health Preparedness Capabilities: National Standards for State and Local Planning. The interim crosswalk is being finalized, and it is anticipated that it will be available late Spring 2017. After CDC updates the Public Health Preparedness capabilities, the working group will begin developing an updated version of the crosswalk, including the 2015 National Preparedness core capabilities and the 2017-2022 Health Care Preparedness and Response Capabilities. It is anticipated that CDC will begin updating the Public Health Preparedness Capabilities late Summer 2017.

Federal agencies participating in the Emergency Preparedness Grant Coordination working group include: Office of the Assistant Secretary for Preparedness and Response (ASPR), Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), Department of Homeland Security (DHS) Federal Emergency Management Agency (FEMA), and the Department of Transportation (DOT) National Highway Traffic Safety Administration (NHTSA).

10. For some of the large HCC with 400 LTC, what degree of participation are you looking for?

Answer: This would best be determined by the individual HCC as far as what their needs are and how best to integrate LTC participation. This may be guided by the strategic plan and goals of the individual HCC as well as HCC preparedness and response plans.

An HCC member is defined as an entity within the HCC's defined boundaries that actively contributes to HCC strategic planning, identification of gaps and mitigation strategies, operational planning and response, information sharing, and resource coordination and management. In cases where there are multiple entities of an HCC

member type, there may be a subcommittee structure that establishes a lead entity to communicate common interests to the HCC (e.g., multiple dialysis centers forming a subcommittee). HCC membership does not begin or end with attending meetings.

11. Do we have a projected month or date for templates?

Answer: We anticipate having healthcare coalition preparedness and response plan templates by the end of March 2017. Additional resources, tools, and templates will be developed throughout 2017 to also assist coalitions. All resources will be available through ASPR TRACIE.

12. Can funding for the upcoming project period be given directly to hospitals or does it have to be directed to the Healthcare coalition?

Answer: HPP funding must primarily support strengthening health care system preparedness through the collaborative development of HCCs that prepare and respond as an entire regional health system, rather than individual health care organizations. HPP recognizes that, at the conclusion of the previous project period, some awardees only funded HCCs, some funded individual health care entities (with a requirement that they participate in regional preparedness efforts), and others funded a mixture of HCCs and individual health care entities.

For Budget Period 1, ASPR still permits providing direct funding from the awardee to individual health care entities for regional preparedness efforts; however, ASPR expects that as the project period progresses, the awardee's funding strategy will include allocating funding to HCCs in a graduated manner – such HCC funding should increase incrementally over the five-year project period. As awardees allocate more funding to HCCs each year, individual health care entities can continue to receive HPP funding, through the HCC, to ensure regional coordination and collaboration. HCCs will determine the amount of funding for health care entities upon review of coalition projects, as well as health care entity projects, based on the funding priorities for each budget period. This process will ensure that HCC activities contribute to the overarching readiness, preparedness, and resilience of health care systems.

13. How would the lack of a FY17 federal budget agreement affect availability of funding?

Answer: We are unable to comment on unknown budgets at this time. When funding determinations are made, HPP will communicate those and any implications through the normal grant management process.

14. With established non funded HCC's already in place will they be expected to find a way to govern funds in the future? Whereas we see PHEP with Public Health and HPP with Hospitals currently. Will we be looking at having HCC Coordinators expected to complete deliverables that have previous fallen under PH and Hospitals?

Answer: Additional information on 501c3 will be coming out in the supplemental guidelines. There will certainly need to be a mechanism to procure goods and services and how the HCCs achieve that will be as individual as the HCCs themselves. Some may

have one of the HCC members step up and be able to be the fiduciary agent for the entire HCC, other HCCs may look toward becoming 501c3. However, each is not without its challenges and this should be a discussion within the HCC. But yes, there will need to be some fiscal agent to manage the grant.

As far as responsibility for the deliverables, the FOA does provide that outline of deliverables for awardee and HCCs. If there are members that receive funds through the HCC, there should be a mechanism of accountability within the HCC to ensure that the facility is on track with the project or purchase they requested and they (the facility) has been a good steward with the funds. I think this will warrant more discussion within our division on this since this concept is just taking hold and whether the accountability remains with the HCC and reported back through the end of year report, or FPO site visit, may still be determined.

15. During the webinar I heard mention about HCCs should be arranged by patient movement and not having to follow along political/county boundaries...which make a lot of sense to me for a state like Colorado where mountain ranges divide many of our counties. After the webinar in discussion with my staff, I was told we are required to report HCC boundaries by county. Did I misunderstand that HCCs don't need to fit county political boundaries? If so, how do we address the reporting requirement that says to report by county...or does my staff have that part wrong?

Answer: ASPR defines an HCC member as an entity within the HCC's defined boundaries that actively contributes to HCC strategic planning, identification of gaps and mitigation strategies, operational planning and response, information sharing, and resource coordination and management. When defining the HCC boundaries, awardees and HCCs must consider daily health care delivery patterns, corporate health systems, and defined catchment areas, such as regional emergency medical services (EMS) councils, trauma regions, accountable care organizations, emergency management regions, etc. HCC boundaries may span several jurisdictional or political boundaries. Please note that due to cooperative agreement restriction, funding must be limited HCCs within awardees' jurisdictional boundary. HCC boundaries should encompass more than one of each member type, such as hospitals and EMS, to enable coordination and enhance the HCC's ability to share the load during an emergency. Once boundaries are established, HCCs must coordinate with all ESF-8 lead agencies within those defined boundaries. HCCs serve as multiagency coordination groups that should support and integrate with ESF-8 activities.

Coordination between the HCC and the ESF-8 lead agency can occur in a number of ways. Some HCCs serve as the ESF-8 lead agency for their jurisdiction(s). Others integrate with their ESF-8 lead agency through an identified designee at the jurisdiction's emergency operations center (EOC) who represents HCC issues and needs and provides timely, efficient, and bidirectional information flow to support situational awareness. With funding provided, HPP expects awardees to refine and/or sustain HCCs through the end of the five-year project period. Further, awardees must work collaboratively with each HCC and its members including by defining all HCC boundaries in their jurisdictions.