



ASPR

The Role of Surge Partners in Disasters

National Healthcare Coalition Preparedness Conference
December 5, 2019

Speakers

- Shayne Brannman, MS, MA, ASPR TRACIE Program Director
- Caecilia Blondiaux, Division of Acute Care Services (DACS), Quality, Safety & Oversight Group (QSOG), Centers for Medicare & Medicaid Services
- Meghan Treber, MS, ICF TRACIE Program Director
- Tina Wright, Director of Emergency Management, Massachusetts League of Community Health Centers
- Lou Ellen Horwitz, MA, Director of Staff Development and Communications, Retail Health and Community-Based Care, MultiCare Health System
- James Paturas, MPA, Director, Center for Emergency Preparedness and Disaster Response, Yale New Haven Health

ASPR's Priorities: Building Readiness for 21st Century Threats



Why ASPR TRACIE?

ASPR TRACIE was developed as a healthcare emergency preparedness information gateway to address the need for:

- Enhanced and rapid technical assistance
- A comprehensive, one-stop, national knowledge center for healthcare system preparedness
- Multiple ways to efficiently share and receive information between various entities, including peer-to-peer
- A way to leverage and better integrate support (force multiplier)
- Helping prepare deployed and field staff via our Technical Resources and Subject Matter Experts

ASPR TRACIE: Three Domains



- Self-service collection of audience-tailored materials
- Subject-specific, SME-reviewed “Topic Collections”
- Unpublished and SME peer-reviewed materials highlighting real-life tools and experiences



- Personalized support and responses to requests for information and technical assistance
- Accessible by toll-free number (1844-5-TRACIE), email (askasprtracie@hhs.gov), or web form (ASPRtracie.hhs.gov)



- Area for password-protected discussion among vetted users in near real-time
- Ability to support chats and the peer-to-peer exchange of user-developed templates, plans, and other materials



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1-844-5-TRACIE



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CMS Emergency Preparedness Rule

What's New Based on the Medicare and Medicaid Programs;
Regulatory Provisions to Promote Program Efficiency,
Transparency, and Burden Reduction Final Rule

Caecilia Blondiaux

Division of Acute Care Services

Quality, Safety & Oversight Group

Centers for Medicare & Medicaid Services

Final Rules

- Original Emergency Preparedness Final Rule: *Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers* (2016)
- Revisions to Emergency Preparedness Requirements: *Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction* (2019)

Important Reminders

- The Final Rule for Emergency Preparedness published in 2016 and provisions were updated with the Burden Reduction Final Rule.
- Emergency Preparedness still applies to all 17 provider and supplier types
- Compliance required for participation in Medicare
- Emergency Preparedness is ONE CoP/CfC of many already required

Four Provisions for All Provider Types



Primary Changes as of 2019's Burden Rule

- **Review & Updates:**
 - Plans, policies and procedures, communication plan **reduced to at least every 2 years** (annually for LTC). Review/updates should still occur as needed with changes.
- **Training/Testing**
 - For inpatient providers, expanded the types of acceptable testing exercises that may be conducted.
 - For outpatient providers, revised the requirement such that only one testing exercise is required annually, which may be either one community-based full-scale exercise, if available, or an individual facility-based functional exercise, every other year and in the opposite years, these providers may choose the testing exercise of their choice.

Risk Assessment and Planning

- Develop an emergency plan based on a risk assessment.
- Perform risk assessment using an “all-hazards” approach, focusing on capacities and capabilities.
- Facilities must still have a process for cooperation and collaboration with local, tribal (as applicable), regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation.
Facilities should be able to describe the process, but it no longer needs to be documented in writing (2019).
- Update emergency plan at least every 2 years (annually for LTC)

All-Hazards Approach:

- An all-hazards approach is an integrated approach to emergency preparedness that focuses on identifying hazards and developing emergency preparedness capacities and capabilities that can address those as well as a wide spectrum of emergencies or disasters.
- This approach includes preparedness for natural, man-made, and or facility emergencies that may include but is not limited to: care-related emergencies; equipment and power failures; interruptions in communications, including cyber-attacks; loss of a portion or all of a facility; and, interruptions in the normal supply of essentials, such as water and food; and emerging infectious disease (EID) threats.

Policies and Procedures

- Develop and implement policies and procedures based on the emergency plan and risk assessment.
- Policies and procedures must address a range of issues including subsistence needs, evacuation plans, procedures for sheltering in place, tracking patients and staff during an emergency.
- Review and update policies and procedures at every 2 years (annually for LTC).

Communication Plan

- Develop a communication plan that complies with both Federal and State laws.
- Coordinate patient care within the facility, across healthcare providers, and with state and local public health departments and emergency management systems.
- Review and update plan at least every 2 years (annually for LTC).

Training and Testing Program

- Develop and maintain training and testing programs, including initial training in policies and procedures.
- Demonstrate knowledge of emergency procedures and provide training at least annually.
- Conduct drills and exercises to test the emergency plan.

New Definitions for Training/Testing

- **Functional Exercise (FE):** “FEs are designed to validate and evaluate capabilities, multiple functions and/or sub-functions, or interdependent groups of functions. FEs are typically focused on exercising plans, policies, procedures, and staff members involved in management, direction, command, and control functions” as defined by HSEEP. We are aligning our definitions with those guidelines.
- For additional details, please visit HSEEP guidelines located at https://preptoolkit.fema.gov/documents/1269813/1269861/HSEEP_Revision_Apr13_Final.pdf/65bc7843-1d10-47b7-bc0d-45118a4d21da

New Definitions for Training/Testing

- **Mock Disaster Drill:** A drill is a coordinated, supervised activity usually employed to validate a specific function or capability in a single agency or organization. Drills are commonly used to provide training on new equipment, validate procedures, or practice and maintain current skills.
- For example, drills may be appropriate for establishing a community-designated disaster receiving center or shelter. Drills can also be used to determine if plans can be executed as designed, to assess whether more training is required, or to reinforce best practices.

New Definitions for Training/Testing

- **Workshop:** A workshop, for the purposes of this guidance, is a planning meeting/workshop which establishes the strategy and structure for an exercise program. We are aligning our definitions with those guidelines. For additional details, please visit HSEEP guidelines.

Training Requirements

- Conduct initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers
- After initial training, provide emergency preparedness training every 2 years (Annually for LTC)
- Demonstrate staff knowledge of emergency procedures.
- Maintain documentation of all emergency preparedness training.
- If the emergency preparedness policies and procedures are significantly updated, conduct training on the updated policies and procedures.

Testing Changes with Burden Reduction

- **For inpatient providers:** The types of acceptable testing exercises are expanded. Inpatient providers can choose one of the two annually required testing exercises to be an exercise of their choice, which may include one community-based full-scale exercise (if available), an individual facility-based functional exercise, a drill, or a tabletop exercise or workshop that includes a group discussion led by a facilitator.
- **NOTE:** For LTC facilities, while the types of acceptable testing exercises was expanded, LTC facilities must continue to conduct their exercises on **an annual basis**.

Testing Changes with Burden Reduction

- **For outpatient providers:** Facilities are required to only conduct one testing exercise on an annual basis, which may be either one community-based full-scale exercise, if available, or an individual facility-based functional exercise, every other year and in the opposite years, these providers may choose the testing exercise of their choice.
- These outpatient providers are required to conduct one full-scale or individual facility based exercise every two years, and in the opposite years, the providers can conduct testing exercise of choice, which can include either a full-scale, individual facility-based, drill, tabletop or workshop which includes a facilitator.

Testing Exercises- Reminder

- CMS is not specifying a minimum number of staff which must attend these exercises, however facility leadership and department heads should participate in each exercise.
- If an exercise is conducted at the individual facility-based level and is testing a particular clinical area, the expectation is that staff who work in this clinical area participate in the exercise for a clear understanding of their roles and responsibilities.

Testing Exercises- Reminder

- Additionally, facilities can review which members of staff participated in the previous exercise, and include those who did not participate in the subsequent exercises to ensure all staff members have an opportunity to participate and gain insight and knowledge.
- A sufficient number of staff should participate in the exercise to test the scenario and thoroughly assess the risk, policy, procedure, or plan being tested

Temperature Controls and Emergency and Standby Power Systems

- Under the Policies and Procedures, Standard (b) there are requirements for subsistence needs and temperature controls for inpatient facilities.
- Additional requirements for hospitals, critical access hospitals, and long-term care facilities are located within the Final Rule under Standard (e) for Emergency Power and Stand-by Systems.
- If surveyors are unclear if the E-Tags cross over to the K-Tags for LSC for provider/suppliers affected by LSC, then they should consult with the LSC surveyor

Where are we now?

- Our Surveyor Training (available publically) is under development to reflect these new changes.
- Appendix Z updates are in progress and forthcoming.
- Changes are effective upon implementation of this Final Rule- no grace period.
- Facilities continue to be surveyed in conjunction with scheduled surveys and survey cycles based on their provider types.

Reminders and Important Notes

- While we encourage the use of healthcare coalitions, we recognize this is not always feasible for all providers and suppliers.
- For facilities participating in coalitions, we are not specifying the “level” of participation. However, if facilities use healthcare coalitions to conduct exercises or assist in their efforts for compliance, we ask this would be documented and in writing.

Reminders and Important Notes

Continued

- When developing transfer agreements, facilities must take into account the patient population and the ability for the receiving facility to provide continuity of services.
- If a facility has a transfer arrangement with another facility and this facility could not accommodate all patients, then the facility should plan accordingly to provide continuity of services with another facility who could receive the remaining residents.

Reminders and Important Notes

Continued

- Facilities should also take into account the availability of contracted resources during an emergency event. For instance, a facility has a written arrangement with a transportation company, yet during an emergency the transportation company is unable to reach the facility due to flooding and/or having other arrangements with the community.
- The facility is responsible to ensure these areas are discussed and managed within their policy and procedure to ensure availability of resources during an emergency event.
- It would be appropriate for the facility to have discussions with transportation vendors about their competing contracts during an emergency and the vendor's continuity of business plans in the event of an emergency.

State Requirements & Accrediting Organizations

- The Emergency Preparedness Rule does not specify quantities within any provisions. The rule is broad and overarching.
- Facilities should check with their State Survey Agencies and Accrediting Organizations (as applicable) for any specific non-CMS requirements which may exceed the Final Rule.

Life Safety Code v. Emergency Prep

- Additionally, Hospitals, CAHs, NHs, Inpatient Hospices, ASCs, ICF-IIDs, RNHCIs, and certain ESRDs all have life safety from fire protection CoPs/CfCs that require compliance with the LSC. The LSC typically requires an emergency power system/generator to provide **limited** emergency power in Hospitals, CAHs, NH, Inpatient Hospice and ASCs.
- Therefore, in these facility types, as determination has to be made whether a deficiency is associated with an EP requirement that goes beyond what is required by the LSC. **It is recommended that health surveyors who perform EP evaluations consult with their LSC survey team colleagues to make this determination.**

Compliance

- Facilities are expected to be in compliance with the EP requirements with these changes effective 11/29/2019.
 - Note: these changes only reflect the revised emergency preparedness provisions, not the other Burden Reduction changes.
- In the event facilities are determined non-compliant, the same general enforcement procedures will occur as is currently in place for any other conditions or requirements cited for non-compliance.

The QSOG EP Website

- Providers and Suppliers should refer to the resources on the CMS website for assistance in developing emergency preparedness plans.
- The website also provides important links to additional resources and organizations who can assist. We will be working on revisions to FAQs and other resources for the next several months to reflect the new changes
- <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html>

Use the Checklists

- We would recommend both surveyors and facilities use the checklists developed by ASPR to help guide them to their specific requirements.
- Review the checklists under Facility-Specific Requirement Overviews at <https://asprtracie.hhs.gov/cmsrule>
- Consider annotating on the checklist, the location of each of your elements of the plan to assist surveyors reviewing on-site.

Thank you!

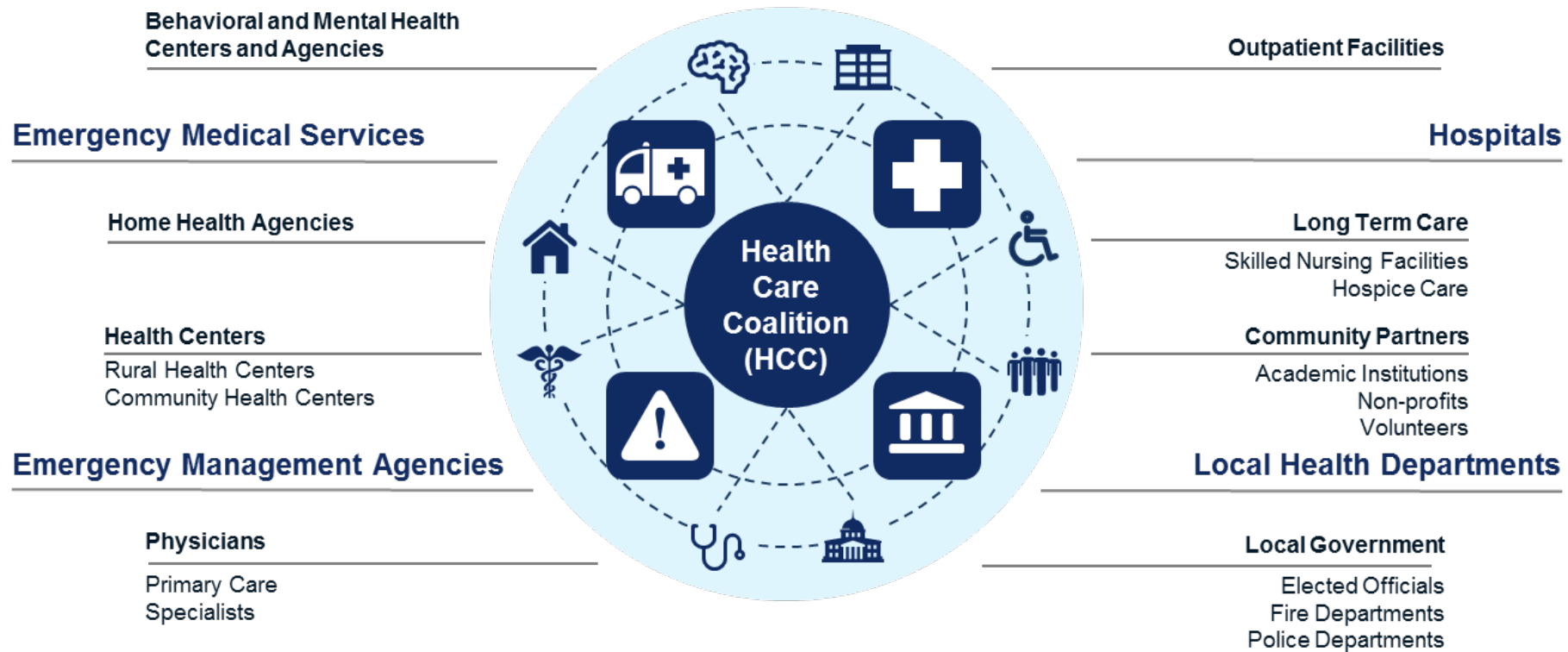


QSOG_EmergencyPrep@cms.hhs.gov

Meghan Treber, MS, ICF TRACIE Program Director

HCCs: Coordinating a Regional Approach to Healthcare and Medical Response

An HCC is a group of individual healthcare and response organizations in a defined geographic location. HCCs play a critical role in developing healthcare preparedness and response capabilities.



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Expanding Healthcare and Medical Response Coordination

- Urgent Care Centers
- Health Clinics (Federally Qualified Health Centers, Rural Health Clinics)
- Practice-Based Primary Care Providers
- Accountable Care Organizations
- Home Health and Hospice Agencies

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Understanding Engagement of Healthcare System Partners in Medical Surge

- Conducted a mix of online surveys and telephone interviews.
- Topics included:
 - Role of each healthcare setting in infectious disease and no-notice incident scenarios
 - Level of capability and infrastructure for response
 - Characteristics of preparedness activities
 - Status of business continuity efforts
 - Factors that facilitate engagement in emergency management activities

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Key Findings

- Wide variation in capacity and resources.
- Roles not clearly defined in many communities.
- Capabilities exist in:
 - Preventive care and disease management services that make communities more prepared and resilient
 - Treatment for lower acuity patients to help decompress hospitals during response
 - Follow-up care and monitoring during recovery
- Business continuity strategies being implemented.

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Opportunities to Improve Medical Surge Preparedness

- Better define roles in community emergency management efforts.
- Increase engagement between each setting and HCCs.
- Provide supportive training, technical assistance, and other resources.
- Promote knowledge exchange and learning.
- Encourage use of hazard vulnerability analyses.
- Promote continuity of operations planning.
- Support FQHCs, RHCs, home health, and hospice settings in implementing CMS EP Final Rule requirements.

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Resources Developed for Engaging Healthcare System Partners in Medical Surge

- Report, Summary, and Engagement in Surge Activities (Q&A) document for:
 - Accountable Care Organizations
 - Health Clinics
 - Home Health and Hospice Agencies
 - Urgent Care Centers
- Report for:
 - Practice-Based Primary Care Providers
- Available at <https://asprtracie.hhs.gov/surge-partners>



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Tina Wright, Director of Emergency Management, Massachusetts League of Community Health Centers

What Are Health Centers?

- Non-profit, community-directed healthcare providers serving low income and medically underserved communities
- Provide high-quality, affordable primary and preventive care, as well as dental, behavioral health and substance abuse, and pharmacy services
- Located in areas where care is needed but scarce, and improve access to care for millions of Americans regardless of their insurance status or ability to pay.
- Currently, over 1,400 health centers deliver care through over 10,000 service delivery sites in every state and territory.

Founding of the First Two Health Centers in the Nation

Physician-activists
Drs. Jack Geiger & Count Gibson

1965 - The Community Health Center Program is Established

Determined community health and civil rights activists fought more than 50 years ago in **June 1965** to improve the lives of Americans living in deep poverty and in desperate need of health care.

Moving on the opportunity presented by President Lyndon B. Johnson's major **War on Poverty** initiatives in the early 1960s, **Dr. Jack Geiger** and other health care pioneers submitted proposals to the federal Office of Economic Opportunity to establish health centers in medically underserved inner city and rural areas of the country.

Funding for the first two "Neighborhood Health Centers" (in Boston and Mississippi) **was approved in 1965, and the Community Health Centers Program was launched.**



HEALTH CENTERS

are consumer-driven and patient-centered organizations that serve as a comprehensive and cost effective primary health care option for America's most underserved communities. Health centers increase access to health care and provide integrated services based on the unique needs of the communities they serve.

There are **four key components** that define health centers & help them reach America's most underserved communities

1

Located in Areas of High Need

Designated as medically underserved areas or populations by the federal government

2

Comprehensive Set of Services

Based on community needs, health centers offer medical, dental, vision, behavioral health, and enabling services

3

Open to Everyone

Regardless of insurance status or ability to pay, and offer sliding fee scale options to low-income patients

4

Patient-Majority Governing Boards

At least 51% of every health center's governing board must be made up of patients

Who do Health Centers Serve?

In 2019, health centers will serve

over 29 million patients

including:

Nearly **14 million**
people in poverty

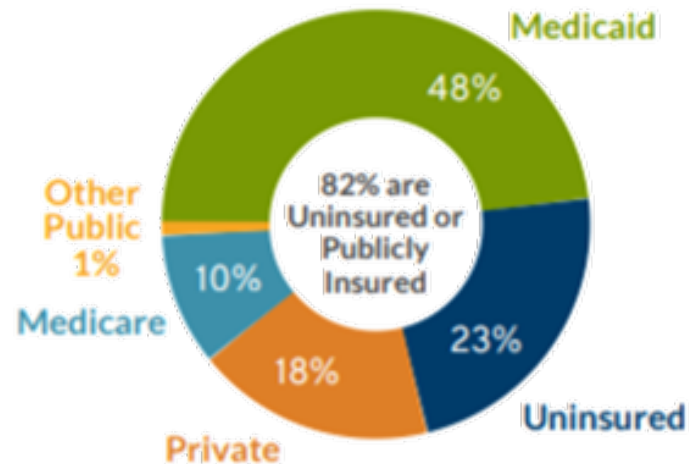
8.7 million
children

1.4 million
homeless patients

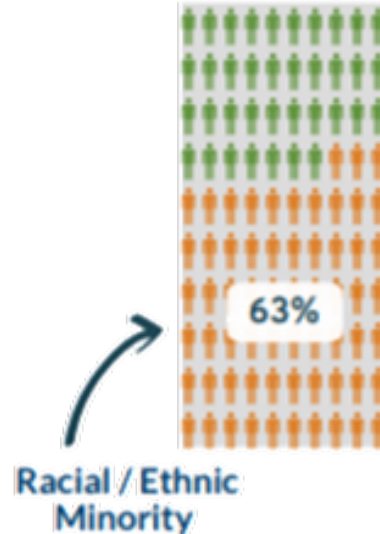
Over **385,000**
veterans

95,000
patients receiving
MAT for opioid use
disorder

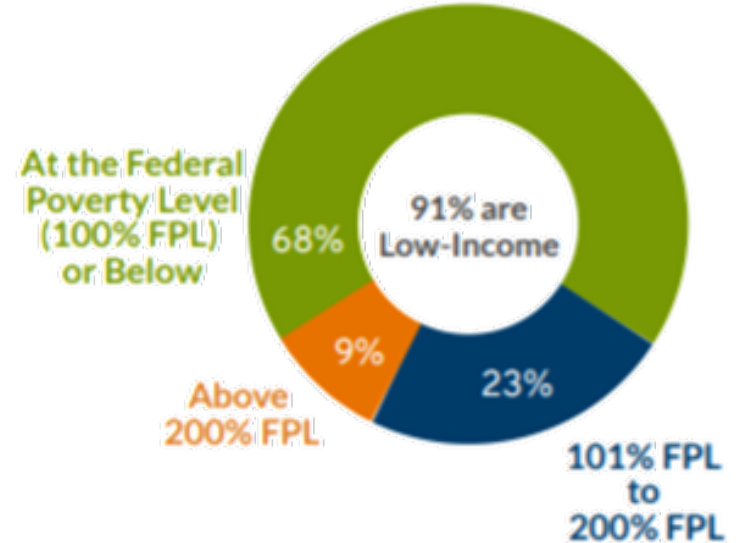
Most Health Center Patients
Are Uninsured or Publicly
Insured (2018)



Most Health Center Patients
Are Members of Racial &
Ethnic Minority Groups (2017)



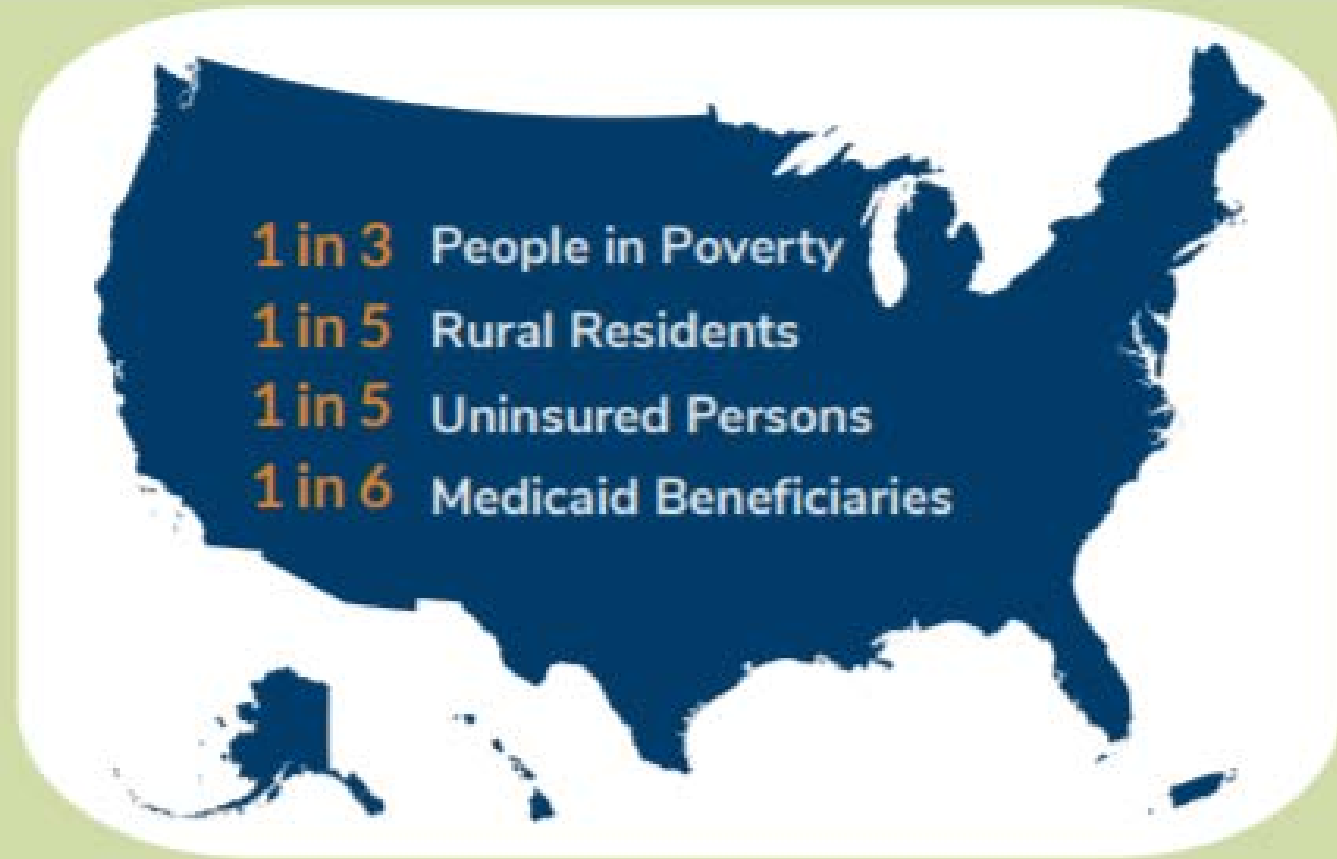
Most Health Center Patients
Have Low-Incomes (2017)



Health Centers Reach Into America's Most Underserved Communities

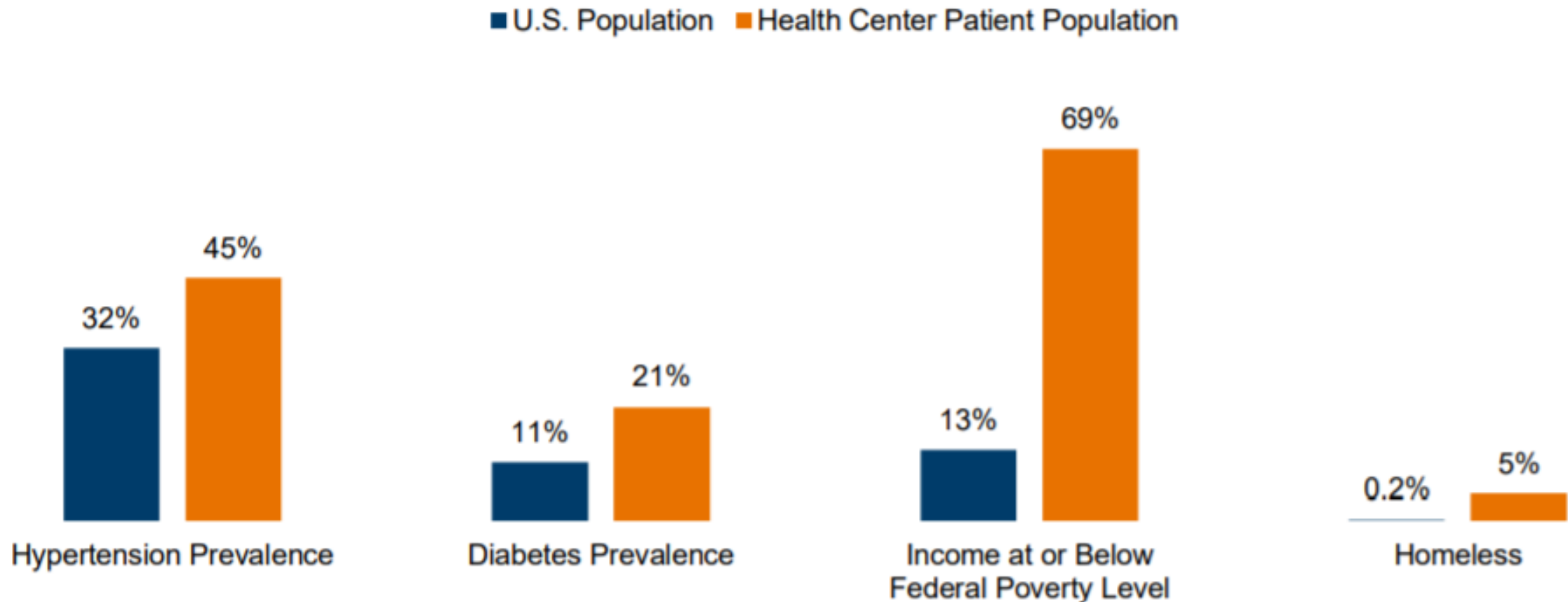
There are over 1,400 health center organizations operating more than 12,000 service delivery locations in every state and territory

Of these,
45% Are Rural Health Centers



Health center patient populations are more complex because they have higher rates of chronic conditions and social risk factors associated with poorer health outcomes.

Percent of U.S. population vs. health center patient population for selected demographics, 2017⁴



A Massachusetts Example



Massachusetts League
of Community Health Centers

As champions for the community, health centers foster a level of grassroots emergency preparedness that reaches deep into the underserved and vulnerable populations they care for daily. The state's community health centers not only play a significant role in maintaining the health of communities, we are recognized as critical and essential partners in local, statewide and national emergency response.

Today, health centers are more than primary care providers – we are **community responders**.



Role of Community Health Centers in our Healthcare System

Everyday: Pediatrics, Adult Medicine, Family Medicine, Obstetrics, Gynecology, Laboratory, Dental Care, Mental Health, Social Services, Dermatology, Podiatry, Acupuncture, Elder Services, Hospitalization, Home Care, Nutrition/WIC, Specialty Referrals, Public Health Programs, School Based Services, Pharmacy, Eye Care, Smoking Cessation, Immunizations, Fitness Programs, Substance Abuse Counseling & Treatment, HIV/AIDS Screening, Counseling & Treatment, Youth Peer Counseling



Roles in Emergencies

- Surveillance of unusual outbreaks and diseases
- Health education of community and patients
 - Internal staff education, clarification and identification of staff roles
- Vaccination and mass prophylaxis



Roles in Emergencies, cont.



- Strengthen capacity to address post-event public demands, i.e. behavioral/mental health
- Outpatient surge capacity and triaging systems
- Integrated role in local and regional emergency response efforts

Massachusetts Bay Transportation Authority
Rapid Transit/Key Bus Routes Map

Legend

- RL** RED LINE
- M** MATTAPAN LINE
- OL** ORANGE LINE
- BL** BLUE LINE
- GL** GREEN LINE and branches
- SL** SILVER LINE and branches
- COMMUTER RAIL**
- KEY BUS ROUTE**
- FERRY**
- ACCESSIBLE STATION**
- RAPID TRANSIT TRANSFER STATION**
- COMMUTER RAIL TRANSFER STATION**
- FREE LOGAN AIRPORT SHUTTLE BUS**
- AMTRAK SERVICE**
- CUSTOMER COMMUNICATIONS & TRAVEL INFO**
- MBTA TRANSIT POLICE**
- ELEVATOR/ESCALATOR/LIFT UPDATES**

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National Health Reform and Accountable Care Organizations

An Accountable Care Organization (CMS ACO or commercial Accountable Care solution) is a distinct legal entity consisting of providers who agree to share accountability for the quality, cost and overall coordination of care for a defined set of members or beneficiaries assigned to them or enrolled with them.

- Risk stratification
- Predictive analytics and modelling
- Population health management
- Quality Measures
- Capitation
- Data mining

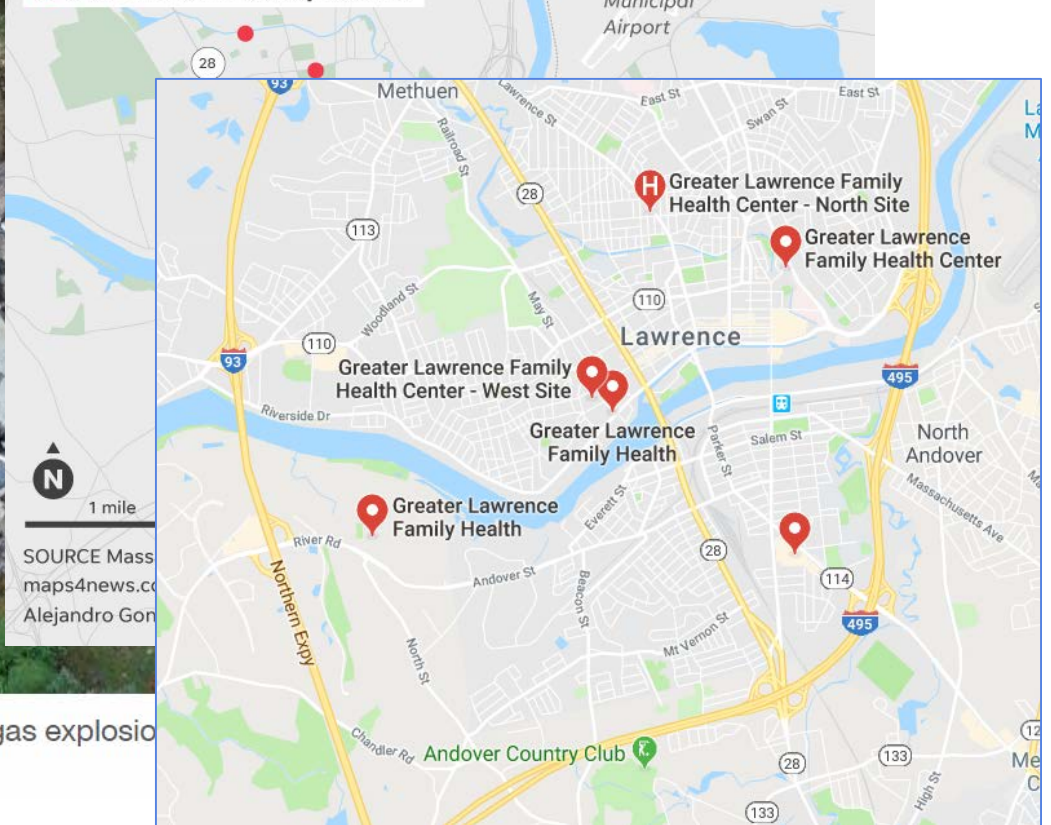
Case Study: 2018 Merrimack Valley Gas Explosions



An aerial view of a burned-out home impacted by the fires and gas explosion in Merrimack Valley on September 13, 2018.

Homes set ablaze in Massachusetts after natural gas issues

● Confirmed fires/explosions



Case study: 2018 Merrimack Valley Gas Explosions

By the numbers:

- 130+ structures, 15 homes destroyed
- 1 fatality, 3 people critically injured & 25 other injuries were sent to area hospitals
- 50,000+ people evacuated, displaced in shelters/ temp housing for many weeks and months
- 5 GLFHC facility sites in explosion area
 - 160+ staff directly impacted
 - The 1 fatality was a patient
 - 1 site lost gas utility for 1 week

Lessons/Successes for Improved Resilience

INTERNAL

- Confident in ability to evacuate staff and patients safely and effectively
- Internal staff communications and notifications
- Successful evacuation of vaccines to reduce losses
- Due to the day of the week of the incident, only lost 1-day of services to patients and half-day of urgent care visits; reconstituted sites Monday and mitigated loss of gas utility with supplemental equipment

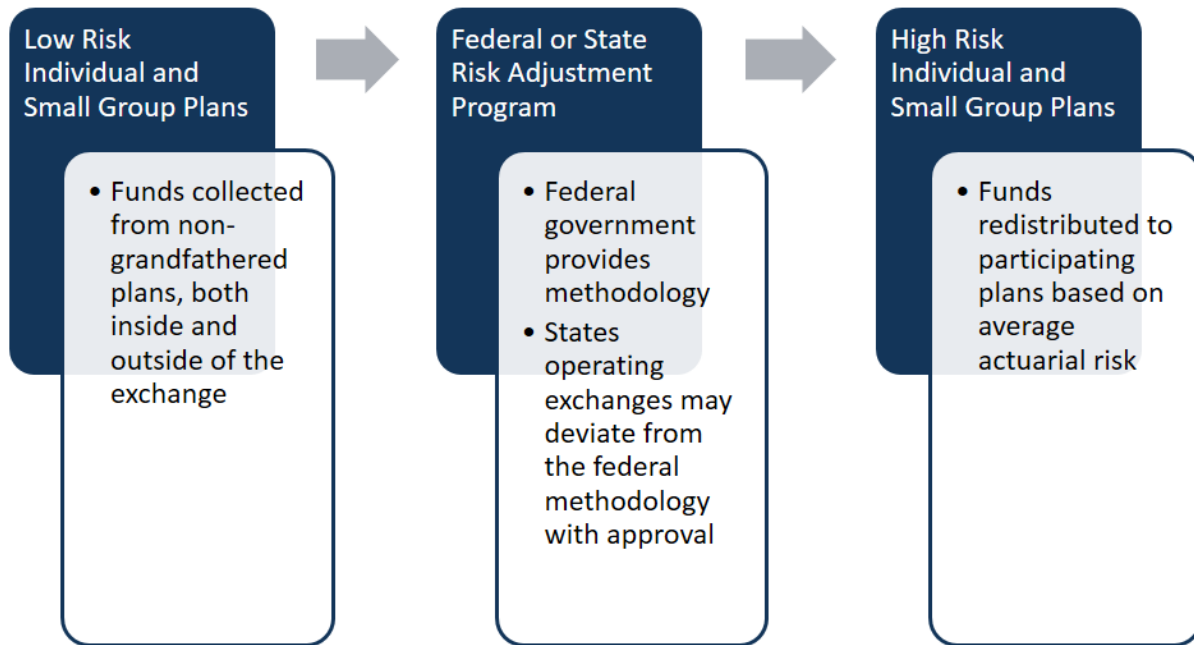
EXTERNAL

- Notification of local and state agencies
- Deployment of staff to support local response operations
- Establishing status with local emergency management director as critical infrastructure for prioritization of utility restoration
- Establishing mechanism to receive external resource for the support of staff and patients impacted by the disaster

Do Risk Adjustments Happen?

Figure 1

Risk Adjustment Under the Affordable Care Act

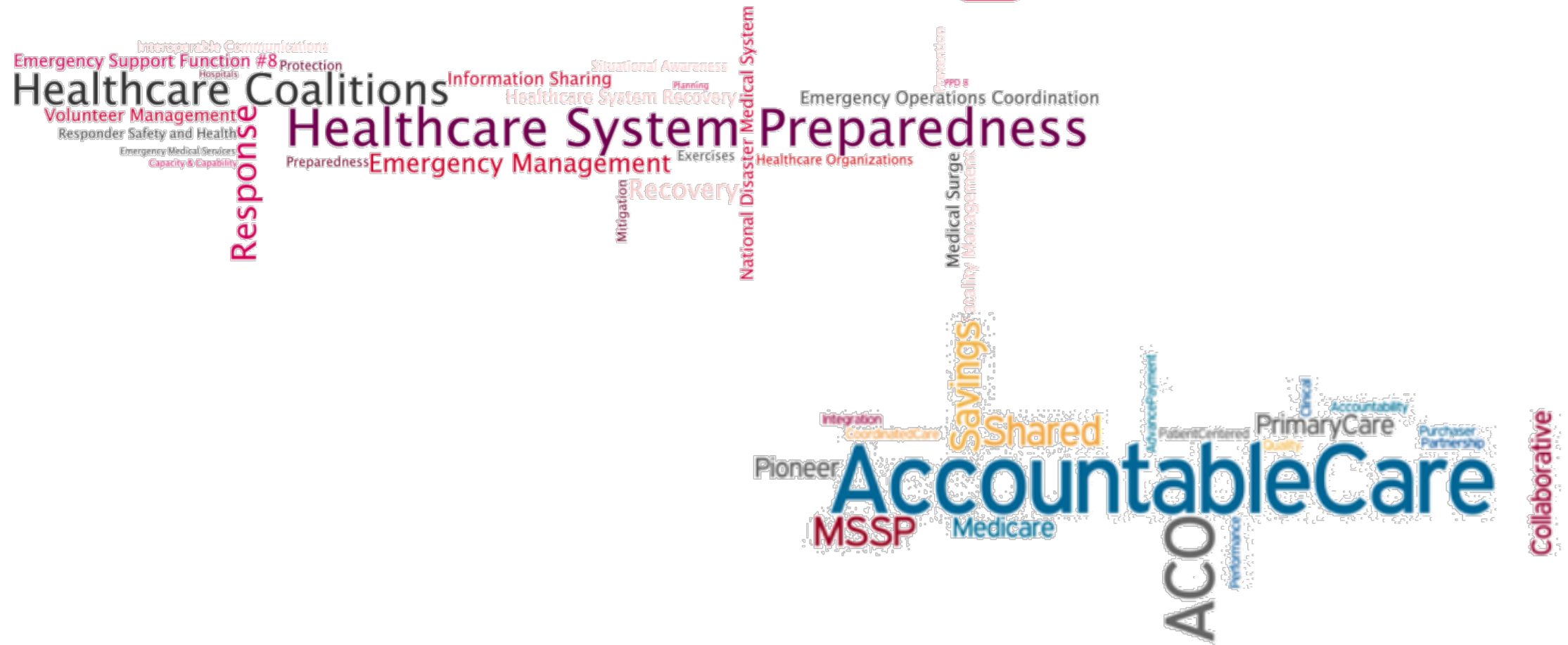


Source: Kaiser Family Foundation



- ACOs are new and evolving, is there room for building in flexibility for those who survive disasters?
- ACOs do not speak Emergency Management
 - “What is a line?”
- Healthcare emergency management does not speak ACO and healthcare reform

Can we Talk?



Meghan Treber Presenting on Behalf of:

**Barbara Citarella, RN, BSN, MS, CHCE, NHDP-BC, President,
RBC Limited Healthcare & Management Consultants**

Home Care and Hospice

Hospice

- Much of hospice care is provided in the home but can also be provided in facilities such as nursing homes, inpatient hospice facilities, and at times, in hospitals.
- Almost 5000 hospices in the country (Source:CMS)
- Provide a myriad of services including pharmaceuticals



Home Care and Hospice

- Home Care/Home Healthcare is provided in the patient's home. Often the patients are referred to as "invisible patients."
- This is one-on-one care. Very labor intensive.
- Medicare certified home health agencies provide skilled intermittent care for a finite period of time. Approximately 12,200 agencies in the United States. (Source: CMS)

Home Care and Hospice

- In addition to Medicare certified home health agencies, there are agencies that are referred to as “home care agencies.”
 - They provide: skilled, non-skilled, consumer directed care, private duty and private pay.
- The total number of these agencies in the United States is unknown.
- There are also patients not in any system. Families provide care.

Home Care and Hospice

Types of Patients



Surge Capacity

Home care and hospice have value for *surge capacity* as history has shown

- Hospital/ER/Urgent Care discharges
- Immunization Clinics
- Distribution of medications
- Treat large volume of actively dying patients
- Treat large number of cohorted patients
- Treat patients in shelters

Great
Pandemic
of 1918

Critical Factors for Determining Home Care and Hospice's Surge Capacity/Capability

- Current Patient Census
- Rural or Urban
- Patient Classification
- Staffing Resources
- Type of Event
- Length of Event

Challenges for the Home Care and Hospice Industry

- Difficulty establishing collaborative partnerships
- Staffing shortages
- Determining and obtaining supply needs during an event
- Knowledge deficit in disaster preparedness concepts, processes, guidelines, and regulations

Lou Ellen Horwitz, MA, Director of Staff Development and Communications, Retail Health and Community-Based Care, MultiCare Health System

Understanding Urgent Care

- Definition: non-life or limb threatening illness/injury
 - Not “retail clinics” (inside a drugstore) or PCP’s with extended hours
 - Lab & X-ray onsite
- Approximately 9279 centers (June 2019), 105 million visits/yr
- 40% physician-owned, 37% hospital owned (*source: UCA White Paper 2019*)
- Majority open 8-8/7/365
- Lacerations, sprains/fractures, contusions, minor burns, rashes, dehydration, URIs, blood testing, imaging, work comp

Urgent Care Centers – Roles in Disasters/Surge

- Self-referrals by educated patients
- Triage to ER
- Referrals from ER
- Diagnosis and treatment of lower-acuity injuries
- Follow-up access & specialist/PCP referrals
- Urgent Care Foundation Disaster Preparedness initiatives

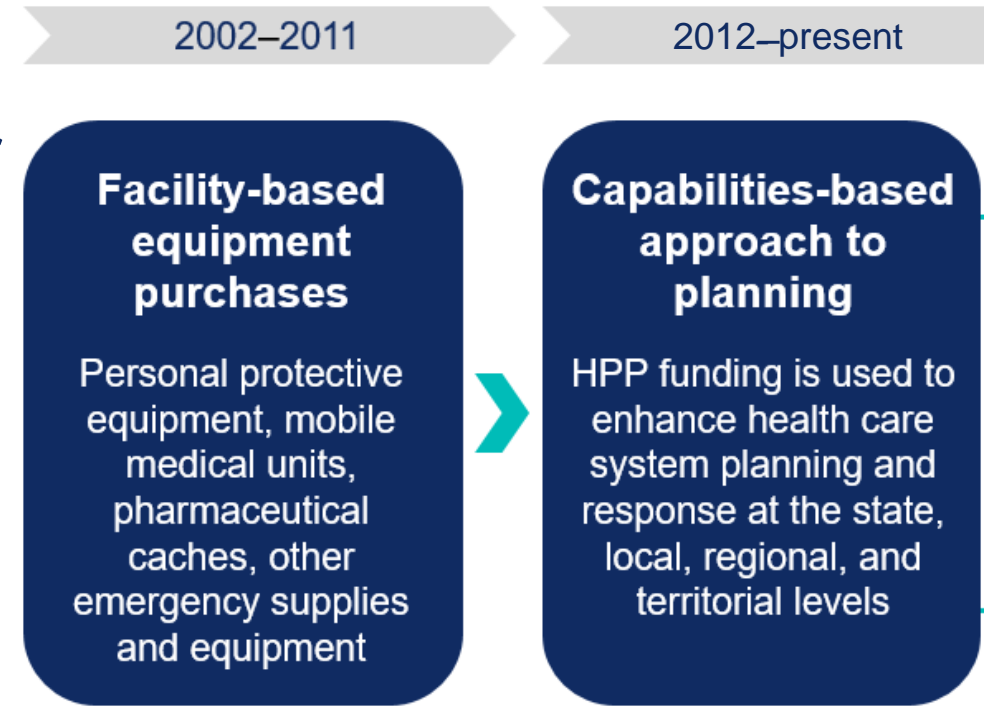
UCC's as Partners – Opportunities & Barriers

- Lack of national or state registry
 - Urgent Care Association
- Lack of standard scope
 - Urgent Care Certification/Accreditation
- Lack of prior partnerships
 - Build relationships
- EMS community
 - Facilitate shared engagement

**James Paturas, MPA, Director, Center for Emergency
Preparedness and Disaster Response, Yale New Haven Health**

Hospital Preparedness Program (HPP)

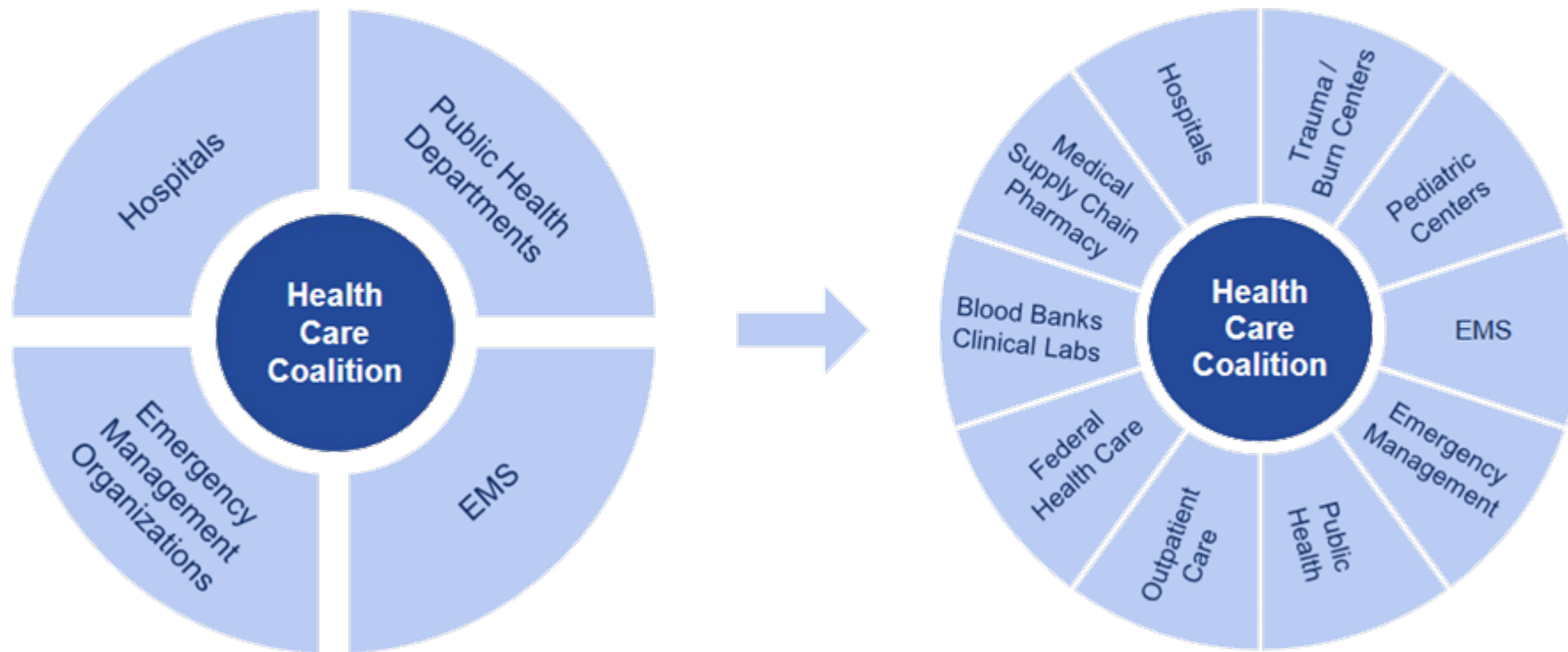
- Development of healthcare coalitions
 - Core membership
 - HCC Readiness and Response Coordinator
 - Clinical Advisor
- 2019-2024 Healthcare Preparedness and Response Capabilities
 - Foundation for healthcare and medical readiness
 - Healthcare and medical response coordination
 - Continuity of healthcare service delivery
 - Medical surge



ASPR; Harvey, M (2018). Hospital Preparedness Program and the CMS Emergency Preparedness Rule. Available at: https://disasterinfo.nlm.nih.gov/content/files/harvey_hpp_cms_508.pptx

Healthcare Coalition Core (HCC) Members

Core HCC members, **at a minimum**, include: (1) hospitals, (2) public health departments, (3) emergency management agencies, and (4) emergency medical services providers



2019-2024: What is new?

- All HCC in-patient facilities must demonstrate existing transfer agreement specifically to the following specialty care centers:
 - Pediatric Centers
 - Trauma and Burn Centers
- Integrate with Regional Pilot Programs (Regional Disaster Health Response System [RDHRS]):
 - HCCs must integrate their planning, training, exercising, response, evaluation, and situational awareness activities
- The HCC will develop complementary state and coalition-lead annexes to its base surge capacity/trauma mass casualty response plan to manage a large number of casualties with specific needs
 - Five annexes will be developed and tested over the course of five years:
 - Pediatric FY2019
 - Burn FY2020
 - Infectious Disease FY2021
 - Radiation FY2022
 - Chemical FY2023

Regional Disaster Health Response System

HHS ASPR HCC Goal: Capability 4

“Health care organizations deliver timely and efficient care to their patients even when the demand for health care services exceeds available supply. The HCC, in collaboration with the state’s ESF-8 lead agency, coordinates information and available resources for its members to maintain conventional surge response. When an emergency overwhelms the HCC’s collective resources, the HCC supports the health care delivery system’s transition to contingency and crisis surge response and promotes a timely return to conventional standards of care as soon as possible.”

*ASPR. 2017-2022 Health Care Preparedness and Response Capabilities available at:
<https://www.phe.gov/Preparedness/planning/hpp/reports/Documents/2017-2022-healthcare-pr-capabilities.pdf>*

“The proposed RDHRS will be built on a tiered regional framework that emphasizes the collaboration among local healthcare coalitions, trauma centers, public and private healthcare facilities, and emergency medical services to expand access to specialty clinical care expertise and increase medical surge capacity.”

<https://www.phe.gov/Preparedness/planning/RDHRS/Pages/default.aspx>

Barriers

Differences between a Grant and a Federal Cooperative Agreement

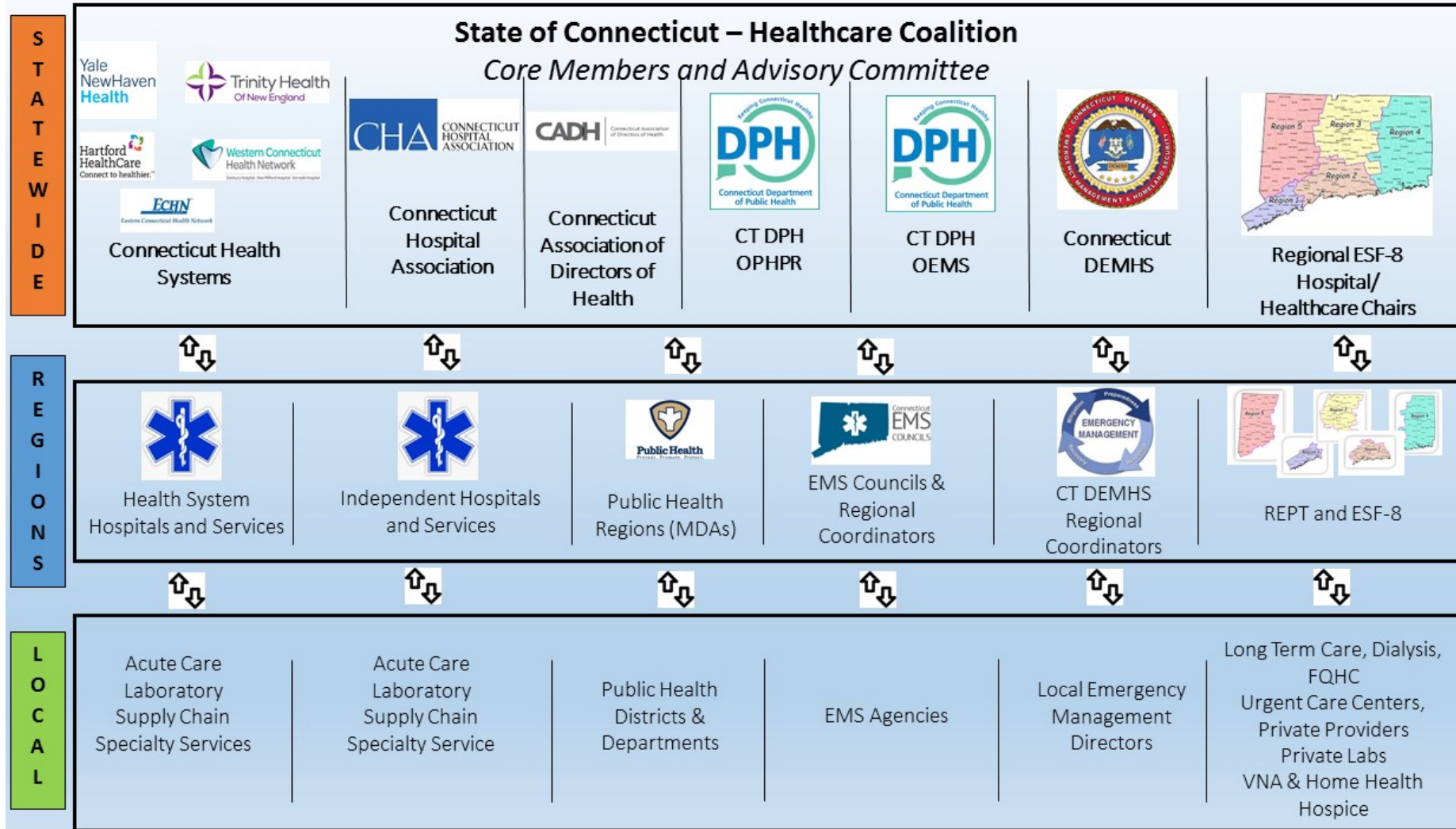
- Grant: Based on the needs of the **awardee**
- Cooperative Agreement: Based on the needs of the **awarder**

“In a cooperative agreement, the federal government is substantially involved in program activities, above and beyond routine monitoring. During the project period, ASPR will monitor and evaluate the defined activities within the agreement and recipient progress in meeting work plan priorities” – **2019 ASPR Funding Opportunity Announcement (FOA), p9.**

Grant	Cooperative Agreement
Payment awarded in annual lump sum	Payment based on deliverables and milestones
Flexible as to scope of work, budget, and other changes	Inflexible as to scope of work, budget, and other changes
No substantial involvement by the U.S. Government	U.S Government determines deliverables to be performed
Steady effort goes towards the completion of work and the delivery of results	Significant emphasis is placed on delivery of results, product, or performance
Annual reporting requirements	Quarterly reporting requirements

The Federal Grant and Cooperative Agreement Act of 1977 (31 USC 6301-6308)

Statewide HCC Example





“It is not the strongest of the species that survive, nor the most intelligent that survives, it is the one most responsive to change.”

- *Charles Darwin*

Audience Discussion and Q&A



Link to Today's Presentation

<https://asprtracie.hhs.gov/conference-resources>