

**Measures That Matter Most  
Breakout Session  
July 23, 2009**

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**Summary of Key Points**

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*Note: In addition to the notes from the breakout session, the following text includes comments from the report-out session on measurement and metrics that followed the breakouts.*

***Measuring Healthcare Preparedness***

**Questions A1 and A2: Considering the measures, what are the measures that matter most and least?**

Overall, participants rated the number of hospitals that demonstrated sustained, two-way communication among hospitals during an incident (D3) as the most important measure, followed closely by the number of hospitals that participated in at least one Statewide exercise or incident (C2). By contrast, the total number of exercises (C1) was among the least important measures, as were other demonstrations of two-way communication (D4: list of tier-two partners, D5: number of hospitals with written plans). During group discussion and the report-out, participants explained that demonstrating communication ability and participating in exercises were important considerations, but measures that focus on numbers (e.g., listing the number of exercises completed) may not provide useful information.

Participants rated describing the State's Telecommunications Services Priority (TSP) program challenges (K1) as the least useful measure, followed by the number of sub-State regions that can maintain patients in isolation (H1). While several of the measures appeared on both the "most useful" and "least useful" lists within and between breakout groups, both K1 and H1 fell only on the least useful list. While some ranked the description of National Incident Management System (NIMS) command and management (B4) high on the list of most useful measures, others ranked it relatively high on the list of least useful measures, along with the rest of the NIMS measures.

Some participants said their assessments were influenced by the wording of the measures, which in some cases did not provide enough context to allow users to gather meaningful data or which did not result in data the users find useful. Other participants felt they understood the spirit of the measures, even if the information requested was not, in itself, the most important factor. For example, some said the quantity of exercises performed (C1) is not a vital number, but conducting exercises is key for coalitions, so the measure may have a purpose.

**Question A3: What are your biggest challenges in measurement and assessment and what are some possible solutions?**

Many participants questioned whether the measures correlate with performance and accurately assess an organization's ability to respond during a disaster. The measures are not always well defined, so the intent is not clear, and often the questions asked are poorly constructed. Several noted that numerical measures should be collected in the context of the individual organization, because service areas, populations, and needs vary dramatically across the country. Participants were concerned about the volume of data required and the

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time needed to collect it. The lack of feedback to awardees about the data was a concern (and echoes issues raised at other breakout sessions).

As was mentioned in the breakout sessions on gaps and overlaps in level 1 and 2 capabilities, participants called for better definition and clarification of the measures. They strongly supported the development of a committee of stakeholders to advise on the development of the measures to ensure that they meaningfully assess operational capacity and capability. There was unanimous agreement that an HPP Evaluation Committee should be established. Participants suggested more feedback to awardees, including capturing and publishing lessons learned. Participants gave targeted suggestions for improving specific measures and generally offered ideas on making reporting less complicated and time-consuming for awardees (such as pre-populating web-based templates, streamlining data collection with other agencies, and ensuring that data requested are consistent from year to year).

During discussion, participants stressed that every incident is different, so measures should seek to define, for example, the proportion of a population that was effectively served during an incident. The denominator (the population) varies according to the incident. Some participants described the importance of having staff dedicated to preparedness exercises and data collection. RADM Ann Knebel asked participants to send ASPR descriptions of their best practices and successful measurement tools. A participant said more web-based reporting tools, such as those used by the Centers for Disease Control and Prevention (CDC), would be helpful.

***Situational Awareness***

**Question B1: Name key elements that are indicative of hospital stress.**

The top three indicators were as follows:

- Increased hospital requests for resources/depletion of resources
- Diversion/ambulance backup (i.e., ambulances unable to respond to volume of calls)
- Emergency department (ED) volume increased multi-fold

Participants also noted the number of patients who leave the ED without being seen by a clinician as another key indicator—and a measure that hospital administrators track carefully. The staff-to-patient ratio was recognized by several participants as an indicator, which is affected by other indicators (staff shortages and absenteeism). A participant noted that the percentage of ED beds occupied by patients admitted to the hospital is another strong indicator of stress.

**Question B2: What are the triggers for activation of your hospital disaster plan—including what different triggers create what types of distinct response actions?**

Participants noted that triggers are—and should always be—event-specific and facility specific. As a general trigger, participants cited any external event that would generate surge or negatively affect operations. More specifically, several noted that a failure of critical infrastructure or a declared mass casualty event would trigger their disaster plans.

**Question B3: What actions could CMS take, including new authorities or funding, to assist with hospital response to disasters and public health emergencies?**

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Participants were united in their suggestion that CMS address reimbursement issues for disaster response to ensure that hospitals and other providers are paid for their services and that they have sufficient cash flow to maintain operations in the midst of a response. Participants also felt strongly that CMS should provide short, straightforward communication on policies related to disaster response, such as waivers, variations, and exemptions during a disaster. They urged CMS to be more flexible during disasters. As in other breakout sessions, participants called for more coordination among HHS agencies (specifically ASPR, CDC, and CMS) to standardize measures and expectations for awardees.