

HPP Healthcare Preparedness Capability Review National Call

Capability 1: Healthcare System Preparedness

Meeting Summary

Monday, May 6, 2013

I. Welcome and Introduction to the HPP Healthcare Preparedness Capability Review National Calls

– Robert Scott Dugas, Branch Chief, Hospital Preparedness Program (HPP)

Scott welcomed attendees to the first National Capability teleconference call on Capability 1: Healthcare System Preparedness and its corresponding functions.

The Office of the Assistant Secretary for Preparedness and Response (ASPR) performed a rigorous analysis of literature and program guidance, conducted expert panels, and vetted the capabilities with stakeholders from multiple emergency preparedness agencies as part of the process to finalize the National Healthcare Preparedness Capabilities. ASPR released the *National Guidance for Healthcare System Preparedness* in January 2012, as a strategic planning tool for awardees to target grant dollars and achieve the Capability benchmarks. CAPT Paul Link will describe these processes and Capability 1 functions in more detail and Awardees will present strategies and examples of Capability 1 implementation.

II. Overview of Capability 1: Healthcare System Preparedness

– Paul Link, Field Project Officer, HHS Region IV, HPP

The Hospital Preparedness Program (HPP) initiated the development of the National Healthcare Preparedness Capabilities in conjunction with the Centers for Disease Control and Prevention (CDC) Public Health Preparedness Program (PHEP) Capabilities. ASPR analyzed various documents to develop the HPP Capabilities:

- ASPR National Health Security Strategy (NHSS)
- FEMA Comprehensive Preparedness Guide (CPG) 101: *Developing and Maintaining Emergency Operations Plans*
- FEMA National Preparedness Goal (NPG) and National Response Frameworks (NRFs)
- Presidential Policy Directive 8 (PPD-8)
- Medical Surge Capability and Capacity (MSCC): *A Management System for Integrating Medical and Health Resources During Large-Scale Emergencies*
- MSCC: *The Healthcare Coalition (HCC) in Emergency Response and Recovery*

Specifically, ASPR considered the two goals of the NHSS: *Build community resilience* and *Strengthen and sustain health and emergency response systems* when developing the Capabilities, with an emphasis on improving medical surge. The Healthcare Preparedness Capabilities were vetted with federal offices including HPP, CDC, Department of Homeland Security (DHS), and Emergency Medical Services (EMS) as well as state and local healthcare and hospital representatives. Implementation of these capabilities is critical throughout the disaster cycle and enhanced response has been demonstrated through recent events such as Hurricane Sandy and the Boston Marathon Bombing.

Capability 1 is a unique Capability, as its functions serve as the foundation for the additional HPP Capabilities. Function 1 describes the overall organization of healthcare coalitions (HCCs). Functions 2, 3, 4, and 7 cover capability-based planning and community resilience enhancement including planning, prioritization, resources and at-risk populations. Functions 5 and 6 describe Awardee training and exercise and evaluation activities. Each function is described in more detail below.

Function 1: *Develop, refine, or sustain HCCs*

- **Summary:** The focus of Function 1 is to develop an overarching HCC structure that will facilitate the other functions and capabilities, including the major components of planning, training, equipping, exercising, and evaluating. Function 1 lays out the framework for Awardees and jurisdictions to prepare for, respond to, and recover from a disaster. HPP has built in flexibility in HCC development and structure. However, it is important that Awardees formalize and document these processes and align activities with the National Response Frameworks.
- **ASPR Expectation:** Establish protocols that incorporate the preparedness and response processes for healthcare organizations (including HCC strategy and administrative guidelines) and plans that formalize HCC roles and responsibilities.

Function 2: *Coordinate healthcare planning to prepare the healthcare system for a disaster*

- **Summary:** Capability-based planning is based on community-identified risk and corrective actions are developed to meet objectives and goals.
- **ASPR Expectations:** HCCs will conduct joint risk assessments and develop plans including Medical Surge, Continuity/Recovery, Fatality Management (FM), Information Management, Communications, and Emergency Operations Plans (EOPs).

Function 3: *Identify and prioritize essential healthcare assets and services*

- **Summary:** Objectives and Goals are set based on Operational Priorities.
- **ASPR Expectation:** Resource Development has been prioritized based on risk and need to achieve goals including essential services for Continuity of Operations (COOP). Resource development objectives should be based on HPP Capabilities and requirements and the appropriate individuals should be involved in the planning process.

Function 4: *Determine gaps in the healthcare preparedness and identify resources for mitigation of these gaps*

- **Summary:** Gaps are identified in courses of action and filled using the resources management process.
- **ASPR Expectation:** Awardees will conduct gap analysis, resource assessment, resource development process, and resource tracking/inventory. Awardees should ensure that appropriate individuals are involved in the gap and resource identification process, prioritize these gaps based on capabilities and resources, and understand how these gaps affect state-level processes.

Function 5: *Coordinate training to assist healthcare responders to develop the necessary skills in order to respond*

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Function 6: *Improve healthcare response capabilities through coordinated exercise and evaluation*

- **Summary:** Training is based on gaps identified during the planning process and addresses gaps to mitigate risk. Exercises should test plans to identify strengths and weaknesses. Evaluation should identify strengths and weaknesses and inform the development of Improvement Plans (IPs) and corrective actions.
- **ASPR Expectation:** Development of a comprehensive exercise and training program that complies with Homeland Security Exercise and Evaluation Program (HSEEP) guidance. This program will provide for oversight of performance outlined in the exercise requirements and active improvement planning based on submitted After-Action Reports (AARs) and IPs.

Function 7: *Coordinate with planning for at-risk individuals and those with special medical needs*

- **Summary:** Planning includes at-risk populations.
- **ASPR Expectation:** All emergency plans integrate as-risk populations.

III. Healthcare System Preparedness Performance Measures

– Pamela “Shayne” Brannman, Acting Chief, HPP Healthcare Systems Evaluation Branch

Shayne is leading the Performance Measure (PM) and Data Element Review Process and is working with Dr. Marcozzi and other representatives from HPP and HSEB to accomplish to improve the HPP’s performance measures. ASPR has contracted with a data analytics firm to assist in this process. The goals of this task are to 1) *Reduce* the current number of PMs, 2) *Refine* the remaining PMs to better meet the intent of the capabilities and 3) *Recalibrate* the PMs, as needed, at the end of the grant cycle.

- **Reduce:** Using statistical and qualitative analysis, the team reviewed to PMs to determine which data elements are repetitive and not adding value to the program. The team conducted 150 key informant interviews and reduced 86 data elements down to 30 data elements for the BP1 2012 End-of-Year reporting period.
- **Refine:** In May, the team is focusing on editing and refining the remaining PMs. In order to measure the utility of the PMs, the team is analyzing the relationship between the PMs/data elements and the corresponding capability. The team hopes to develop a more incremental method to track Awardee progress and ensure the data elements meet the intent of the specific capabilities. ASPR will finalize the PMs by mid-June for BP2.
- **Recalibrate:** The team will continue to monitor the PMs, and may need to refine them at the end of the grant cycle. The goal is to stabilize the PMs for data collection and analysis purposes. ASPR is also developing a detailed index of HCC components and definitions to assist Awardees with data collection.

IV. Colorado Public Health and Medical Capacity Building Workshop

- Traci Pole, HPP Region VIII Field Project Officer
- Judy Yockey & Natalie Riggins, Colorado Dept. of Public Health and Environment (CDPHE)
- Christine Billings, Jefferson County Health Department
- Maclaine Butterfass, Exempla Healthcare

Representatives from Region VIII presented the Colorado Public Health and Medical Capacity Building Toolkit (MCBT) at the Public Health Preparedness Summit in Atlanta Georgia. The presentation was very well received and Colorado is willing to share this toolkit with other

Awardees. The MCBT is being finalized and will be ready for distribution after June 14, 2013. Awardees should contact Traci Pole (Traci.Pole@hhs.gov) if interested in receiving the toolkit.

The MCBT provides a framework for HCC planning and development, however, there is flexibility built into the toolkit in planning for HCC structure, membership and activities. HCCs may be formed at the local or regional level and may have a variety of governance structures.

For the Capacity Building workshops to be effective, the facilitator should be familiar with the HPP program and the nuances of specific state healthcare and governance structure. One of the advantages of the MCBT is that it facilitates the understanding of the HCC flexibility, scalability, and progress to date.

Colorado is a strong home rule state, which means its cities and counties have relatively strong jurisdictional power and authority compared to the State. Colorado HPP does not distribute money directly to the HCC. Instead, Colorado HPP directly funds hospitals and local public health. Colorado geography varies greatly, and the mountains act as a natural divider for some areas. The various HCC structures reflect these characteristics.

Christine Billings is the co-lead of the Jefferson County HCC. Jefferson County includes urban areas and mountain areas and lies on the west side of Denver. Jefferson County has two hospitals, and multiple long-term care facilities (LTCFs), dialysis centers, and hospices. In the past, HCC planning has included COOP, mass dispensing, and pandemic planning. The Public Health/Medical Capacity Building workshop brought together these diverse healthcare organizations and encouraged LTCFs to participate in emergency preparedness planning. The workshop was an important step to address the health and medical needs of the county. The MCBT facilitates a strategic approach to HCC development and achieving HPP Performance Measures. Two additional counties became involved in HCC planning and the toolkit facilitated this transition.

Maclaine Butterfass is co-lead of the Hammer Partnership in Boulder County. The Hammer Partnership conducted a two-day workshop utilizing the MCBT. It was emphasized that Awardees need to achieve the benchmarks laid out in Capability 1 as a strong foundation for achieving the remainder of the capabilities. During the workshop, the HCC discovered gaps in meeting Capabilities 1, 2, and 3 and the coalition is currently working to address those gaps by restructuring their organizational chart and adjusting roles and responsibilities based on capability requirements.

In addition, the HCC has a two-year recovery plan (Capability 2), which was not formally documented. The toolkit facilitated the development of three-year and five-year recovery plans and coordination of regional exercises to test these plans.

Judy Yockey (CDPHE) attended various Public Health/Medical Capacity Building workshops. The Hammer Partnership workshop included a half-day table top exercise, which was very productive. The exercise highlighted gaps in achieving the HPP Capabilities and the HCC is currently addressing these issues. The workshop facilitated HCC member understanding of the benefits of HCC participation.

V. Healthcare System Preparedness Function Implementation

- **Function 1: Develop, refine, or sustain HCCs**

- John Wilgis, Florida Hospital Association

Florida's size and geography drives preparedness work and HCC structure. Florida experiences many natural weather events, due to its proximity to the Gulf of Mexico and Atlantic Ocean. Currently, Florida has many HCCs in place that are refining Function 1 activities and confirming appropriate HCC membership. These HCCs have identified their partners and the geographical regions they cover. The current challenge is to ensure that 100% of the population is covered by their services. To accomplish this, Florida HCCs are working on the following activities:

1. **Expanding Membership:** Historically, LTCFs and mental/behavioral health groups have not been involved in Florida HCCs. A statewide workgroup with regional representation is addressing this issue by promoting the benefits of HCC membership. Participation of these organizations is essential in meeting the needs of the entire population.
2. **Refining HCC Organization and Structure:** In some regions in Florida, organizations are collaborating on preparedness and response issues, but these relationships, activities, and outcomes are not formally documented. Therefore, Florida is developing tools and templates to assist HCC efforts to formalize and document these processes.
3. **Training and Exercises:** Response to real events and exercises test how well HCCs will respond together during future emergencies. Currently, Florida is focusing on collaborative training and exercises to test and improve these processes.

- **Function 2: Coordinate healthcare planning to prepare the healthcare system for a disaster**

- Suzet McKinney, Chicago Department of Public Health

The Chicago HCC does not have regulatory or decision-making authority and, therefore, focuses on collaboration and coordination activities. The HCC provides guidance to assist with response efforts without interfering with the authority of hospital executives. Chicago HPP has planned and implemented a variety of activities to prepare HCC partners for an event:

1. **Medical Surge Workshop:** The HCC discovered that hospitals did not fully understand the roles and responsibilities of city government agencies during a response or that emergencies were managed at the city-level. To address this, Chicago HPP conducted a workshop utilizing a medical surge scenario to guide discussion with hospital and healthcare representatives. Participants discussed roles and responsibilities of various healthcare facilities and government agencies during this scenario, which simulated government agencies allocating resources to various hospitals in an emergency. Based on this information, hospitals updated their emergency plans accordingly.
2. **Coalition Emergency Operations Plan (EOP):** At the HCC level, Chicago has developed a coalition-specific EOP that delineates how resources, communication, and overall situational awareness will be managed at the city-level during an emergency. The EOP includes annexes that outline how HCC resources (e.g., communication equipment) will be allocated during a response. HCC partners assisted in the development of the HCC EOP and utilize it

for planning purposes. Chicago tests various aspects of the plan throughout the year. HPP funds support consultants who assist with training and exercise planning and implementation.

3. Governance Documents: Chicago HPP has developed governance documents that guide HCC planning and response activities. These documents outline a HCC Executive Committee and Capability sub-committees and their corresponding focus areas. The sub-committees identify training and exercise needs. The governance documents also support continuous healthcare system emergency planning and the recruitment of additional HCC partners.

- **Function 3: Identify and prioritize essential healthcare assets and services**

- Linda Scott, Michigan Department of Community Health

Michigan has had well-established HCCs in each of their eight regions since 2002 and has integrated HPP, PHEP, and FEMA guidance into their activities. Each HCC has established MOUs, bylaws, and operational guidelines, and has a deep knowledge of the capacity and capability of all of the healthcare organizations and facilities in their region. As outlined in Function 3, this information is essential for interpreting the results from Hazard Vulnerability Analyses (HVAs) and for planning for and responding to emergencies. Capability and HVA data is used to tailor planning, resource allocation, and exercise activities for each organization within the larger HCC framework.

P1. Identify and prioritize critical healthcare assets and essential services: It is obvious that some aspects of a HVA will be incorporated into HCC planning, such as nuclear power plants. However, HCCs must also incorporate more nuanced threats, such as large private industries (e.g., semi-conductor manufacturing plants, chemical plants). In some regions, there are schools for the vision and hearing impaired and HCCs are required to develop strategies to support the needs of these at-risk populations, including equipment and supply purchases and resource allocation.

An example that illustrates these critical processes is the distribution of the pediatric suspension of antivirals during the H1N1 outbreak. CDC distributed antivirals to the state and the state could utilize population and census data to drive distribution. However, as a best practice, the state depended on the expertise of HCC partners regarding pediatric capabilities and gaps to determine a distribution plan for these critical resources.

P2. Priority healthcare assets and essential services planning: P2 activities dovetail into essential elements of *Capability 3: EOC* and *Capability 10: Medical Surge*. P2 outlines communication processes for facilities to request additional assistance in an emergency, based on need.

Each of the eight HCCs has Regional Operational Guidelines based on FEMA's CPG 101 guidance. CPG 101 describes the importance of the foundational EOP and the supplemental annexes/appendices that support the base plan. Michigan HPP and the HCCs have developed a standard template for operational guidelines for all regions to facilitate planning and response activities between the HCCs.

Michigan has a Medical Coordination Center (MCC) at the MSCC Tier 2 level, which develops strategies to support the needs of the healthcare organizations and align assistance with the jurisdiction authority. The processes are outlined in the Regional Operational Guidelines and they are exercised annually by each HCC and utilized during event responses.

E1. Equipment to assist healthcare organizations with the provision of critical services:

Michigan has developed a standardized template for HCCs to track all equipment and supplies purchased with HPP funds. Michigan is in the process of piloting a SharePoint site to track equipment/supply data to facilitate sharing of resources during a response and to increase transparency between HCCs.

- **Function 4: Determine gaps in the healthcare preparedness and identify resources for mitigation of these gaps**

- Leslie Porth, Missouri Hospital Association

Leslie Porth reiterated that the CPG 101 and the MSCC guidance documents are critical. Missouri is utilizing templates that incorporate these documents. In Missouri, HPP has developed industry-specific mutual aid agreements (MAAs) for hospitals and public health. Ninety-five percent of Missouri hospitals have signed MAAs to share, lend, and receive resources, including personnel, during an event response. These MAAs enhance preparedness efforts by establishing procedures for sharing resources.

Missouri also developed a concise Memorandum of Understanding (MOU) for rural communities and small metropolitan areas that build on the industry-specific MAAs. The MOU augments facility EOPs, describes strategies for communicating situational awareness, and outlines HCC structure, roles and responsibilities. The MOU formalizes HCC infrastructure and processes, and will be finalized and signed by July 1, 2013.

One benefit from this rigorous planning response is the development of stronger Tier 1 organizational response. One gap that was found during this analysis was significant variation in hospital emergency codes and announcements. Missouri HPP worked with hospitals to develop standardized emergency code recommendations and a corresponding implementation plan in a very short timeframe (six months). Standardizing emergency codes is a voluntary initiative that, with strong support from hospitals and HCC partners, will launch in January, 2014.

- **Function 7: Coordinate with planning for at-risk individuals and those with special medical needs**

- Mary Keating, Connecticut Department of Public Health

It is important to note that Capability 1, Function 7 aligns with the PHEP *Capability 7: Mass Care*. It is typical for Connecticut Hospitals and healthcare organizations request technical assistance from Regional Emergency Coordinators (RECs) and regional FEMA partners.

P1: Healthcare planning for at-risk individuals and functional needs: Connecticut has well-established HCCs in all of the five Department of Emergency Management and Homeland Security (DEMHS) planning regions. Connecticut historically thought that HCCs had sufficient plans and resources for addressing the medical needs of at-risk individuals. However, recent events, such as Hurricane Irene, Hurricane Sandy, and the significant snow storm in 2011

demonstrated gaps in Connecticut's at-risk planning. HCCs were assuming that various at-risk individuals would need healthcare services during an emergency when some individuals with functional needs would only require sheltering services. Connecticut addressed these issues by enhancing planning efforts and conducting Governor's panels.

At the state level, the Connecticut Department of Public Health, Emergency Management, and the American Red Cross are co-chairs for state-level mass care planning. Connecticut's 169 municipalities have revised and updated the template for local level mass care planning activities, which integrate public health and healthcare partners. Connecticut conducted a statewide mass care sheltering exercise in June 2012, to test how well jurisdictions, public health, and healthcare partners collaborate. During the exercise, partners saw improvement in how the needs of at-risk populations were addressed.

P2. Special medical needs planning: Some of the at-risk populations have special medical needs that the HCC must consider while planning for an event. Regions have formed specialized planning groups with representatives from healthcare organizations and municipal partnerships. When multi-jurisdictional regional shelters are set up, a section of the shelter is dedicated to individuals with special medical needs.

During events where it is difficult to set up shelters at the local or regional level (e.g., 2011 severe winter storm and 2012 Hurricane Sandy), many hospitals developed special medical needs areas. In these cases, hospitals were able to care for individuals that did not need an acute hospital bed, but could monitor individuals with complex medical needs who could not be discharged.

With each successive incident response, Connecticut has noticed an improvement in planning for individuals with functional needs and special medical needs. Connecticut is planning to conduct a statewide exercise on June 20, 2013 using a scenario of a severe winter storm with broad power outages. One region is going to specifically test planning for at-risk populations.

VI. Questions and Answers

– Group

- **Question:** What is the estimated release date for the updated Performance Measures (PMs) for end-of-year 2012 reporting?
 - **Answer:** It is estimated that the updated PMs will be distributed to Awardees by June 1, 2013.
- **Question:** HPP Capability 10: *Medical Surge* aligns with PHEP Capability 10, although HPP's capability has unique components. In the future, is HPP planning to provide guidance to discuss this overlap in order to reduce redundancy in PHEP and HPP reporting requirements?
 - **Answer:** HPP will discuss this issued on the May 30, 2012 National Capability Call which will focus on *Capability 10: Medical Surge*. HPP will coordinate with PHEP to discuss the Public Health components of Medical Surge during this call.

- **Question:** In Connecticut, what role did public health play in hospitals opening community special needs shelters?
 - **Answer:** Connecticut has health departments and health districts, and these operate in different ways. However, jurisdictional leaders may ask public health or healthcare Directors to work with Red Cross on sheltering needs. There is open communication between local public health and healthcare organizations at regularly scheduled monthly ESF-8 meetings and on an ad-hoc basis during an event.

- **Question:** In Connecticut, did hospitals set-up shelters for individuals with special needs on-site or off-site?
 - **Answer:** Some hospitals opened on-site shelters because of necessity. Many individuals needed to be discharged to open beds for acute care cases, but they could not be released from the hospital. During the severe winter storm, when individuals lost power for a week, a hospital opened and staffed an annex area as a community service.

Alternatively, in the Danbury area, hospitals transported staff, including physicians and nurses, to a community shelter to treat individuals with special medical needs. Those hospitals were experiencing surge issues and were at maximum capacity. Individuals treated at the shelter did not have acute medical needs, but had special medical needs that needed to be monitored.

- **Question:** Will HPP distribute the tools and documents that were discussed on this call (e.g., the Colorado toolkit and Chicago EOPs and governance documents)?
 - **Answer:** The documents from Missouri (e.g., mutual aid agreements and MOUs) are in final review by the HCC leaders and will be made available in mid-June. Please contact your Field Project Officer for access to tools and documents discussed on this call.

VII. Concluding Remarks

HPP would like to thank the HPP Field Project Officers and Awardees who presented during today's call and the national Awardee audience for taking the time to participate. HPP encourages Awardees to participate in the following additional upcoming National Capability and Special Topic Calls:

- May 30, 2013 – 2:00 PM ET: Capability 10: Medical Surge
- June 20, 1:00 PM ET: Pediatrics/Pediatric Emergency Care
- July 1, 2013 – 11:00 AM ET: Capability 3: Emergency Operations Coordination
- August 12, 2013 – 11:00 AM ET: Capability 6: Information Sharing
- September 14, 2013 – 11:00 AM ET: Capability 14: Responder Safety and Health