Hospital Preparedness Program
Health Reform and Preparedness Webinar and Teleconference Transcript

November 21, 2013
2:00– 3:30 PM ET

Operator: Good day, ladies and gentlemen. Welcome to the Health Reform and Preparedness Conference Call. At this time, all participants are in a listen-only mode.

Later, we will conduct the question and answer session and instructions will follow at that time. If anyone should require operator assistance during the program, please press star then zero on your touchtone telephone.

I would now like to introduce your host for today's conference call, Mr. Gregg Margolis. You may begin, sir.

Gregg Margolis: Hello, everybody and welcome to the Healthcare Reform and Preparedness Webinar. We're very pleased that we had such an excellent response to this particular topic and would like to thank all of you for taking time from your busy schedule to join us today to talk about this vitally important topic.

The next decade is going to be about - is going to be the most dynamic in the history of the American healthcare system. This is in part due to the passage and implementation of the Affordable Care Act but also due to a variety of other factors that are influencing the healthcare system. We are very excited today to have an opportunity to bring together a number of experts in the field to be able to share with you some of the trends and issues that are going to be impacting healthcare in the next few years.

For anyone that needs a primer or a reminder about the importance of preparedness, I would recommend the book "Five Days at Memorial" in which physician and Pulitzer Prize winning journalist Sheri Fink presents a gripping account of what happens when caring and compassionate healthcare professionals are forced to make impossible decisions due to a lack of preparedness. We have made great strides in this country in preparedness since 2005 in Katrina when the setting of "Five Days at Memorial." But we still have a long way to go in order to ensure that every healthcare facility in the country is sufficiently prepared for disasters and public health emergencies.

This session will help us prepare for the future by understanding the impact that healthcare reform will play on preparedness.

We have an extraordinary lineup today that will help us evaluate these issues.

But as a setup, certainly, one of the major driving forces is going to be payment reform. So in order to discuss the impact of payment and reimbursement and the changing infrastructure for reimbursement and aligning incentives, we have the Chief Medical Officer for the Centers for Medicare & Medicaid Services, Dr. Shari Ling. Another major influencer in the transition of our healthcare system is going to be the role of health information exchange and we're particularly pleased to have Lee Stevens, the Director of the State Health Information Exchange, and John Rancourt, a program analyst, both from the Office of the National Coordinator for Health Information Technology.

We're also pleased to have joining us today, Ms. Catherine Oakar from the Office of Health Reform and to give us a perspective on how this is impacting state preparedness systems, Mr. Michael Harryman from the Oregon Health Authority.

So as I alluded to "Five Days at Memorial" a little bit earlier, one of the quotes that was particularly important to me in reading this book is that it's hard for us to know how we would act under terrible pressure. But we at least have the luxury to picture in advance how we would want to make those decisions. We're pleased today to have a panel of experts on healthcare reform to meet with the emergency preparedness and disaster medicine and public health communities to help understand the impact of healthcare reform in the next couple of years and help us all prepare sufficiently for the future.

With that, it is my distinct pleasure to turn things over to Dr. David Marcozzi who is the Director of the Healthcare Preparedness Program for the Assistant Secretary for Preparedness and Response to give an overview of the thread of preparedness in our nation's healthcare system. Dr. Marcozzi.

David Marcozzi: Dr. Margolis, thanks so much for the introduction. Greetings everybody from D.C. This is a great opportunity for us. I'm hopeful that this is a start to the discussion. This is certainly not the end but could start to shape how we consider what we do today right now to deliver - in delivering healthcare and what we will do during disasters and how we deliver that care.

And blending those two worlds is important and I want to just give a pause to give a thanks to those who are going to be on the phone today from different perspectives at HHS and certainly the state coming together to have this call nationally so we can all be better informed on how to proceed forward.

So with that, I'll pause on my title slide. We can't grant our way to healthcare preparedness. It is important that we weave a thread of preparedness within daily delivery of care. It is the mantra. It is how we think about things towards the future getting eyes up to the horizon so we're trying to achieve that and this is one of the ways we're doing that through this national call.

So a lay down - here's my agenda, A lay down of ASPR 101, the Assistant Secretary for Preparedness and Response, for those who don't know. I'll shift then to put some preparedness considerations, where we are with capabilities and coalitions and performance measures, how we blend and talk about these linkages and then a path forward.

So ASPR is blending of three different worlds really. It is policy, science, and emergency operations. In the upper bullet - upper bubble there is ASPR is the home for BARDA which is the development of appropriate countermeasures to public health emergencies and incentivizes the pharmaceutical industry in essence and research industry to better produce the right pill for those disasters that we needed and when we need it.

In addition to that, we have a policy agenda and we're having some policy discussions here and this is certainly one of those critical intersections that policy and preparedness blends with policy and daily delivery of care. And then lastly, emergency operations, and kudos and a shout out to all our NDMS colleagues, who are out there doing the job and who are on the call here today.

So in ASPR, we think about events like this and how to better respond and Boston did an outstanding job responding to the Boston bombing. However, how can we, as a nation, better prepare for events like Boston or certainly this Hurricane Fran that

rolled up the eastern coast, hitting North Carolina and how do we prepare for events like a no-notice event like a bombing to a large scale event certainly like a hurricane?

So these are some of our challenges and I'll quote Dr. Lurie, "If we can't do it today then we certainly can't do it on game day." There's got -– there is a better appreciation from our preparedness colleagues who think about medical surge, who think about the ability to share information that we need to do and have a better relationship with an understanding of the private sector and how they think about health delivery and really blend with what they're doing.

So in an effort to do that, we try and influence that through the Hospital Preparedness Program. But look, these are some of the realities. We stand on a complex and evolving system as Dr. Margolis spoke to. It resides predominantly in the private sector. And at times and quite often, the public sector's mission doesn't quite blend and jive with the private sector priorities and that's a challenge for all of us.

And the truth is the concepts of medical surge or the concepts of staffed beds just waiting around for patients to fill them conflicts with the ideas of mission versus margin with the just-in-time supply chain and just-in-time staffing principles of which this nation stands on to deliver healthcare from what goes as a private sector revenue generating sector.

Lastly, the preparedness grants and I'm going to speak to those in two seconds is a fraction of the overall $2.8 trillion that's spent on national healthcare expenditures.

This is the reality for the Hospital Preparedness Program. It's a $350 million program currently and the present budget and has it listed at $255 million coming up for 2014.

These are some other data realities. Hospitals' emergency departments are, quite often they're known as the safety net. They're also known as the litmus paper and they predict potentially how things are evolving. And also when emergency departments get stressed, healthcare systems are potentially stressed.

This is one of the pieces to the puzzle and these are some of the realities with regard to emergency departments. As emergency departments are closing their doors (the green line), emergency department visits are actually increasing.

So the reality as we stand on, and the coalitions that we fund are the blue boxes on top of that big black box. We fund that 2-point safety - pardon me - we fund those – the Hospital Preparedness Program and ASPR funds those little boxes on top of that

big black box of the National Healthcare System. So coalition preparedness and I'll speak to coalitions is trying to move towards 100 percent prepared. But the truth is, if mission versus margin is contracting and just-in-time supply chain is moving the nation towards away from capacity, then we're actually potentially moving away from preparedness and not towards it.

And as much as we try and incentivize our coalitions to become better prepared, we need to face the realities of trying to blend in and integrate with how health delivery occurs today to actually achieve that 100 percent prepared.

So what do we need? We need a comprehensive system that's dual use, that's financially sustainable, and this is an exclamation point, that's population-based, a population-based healthcare delivery system for disaster response. Not a -- it has to be population-based through the eyes of a patient-centered focus.

So how do we do that? What is 100 percent prepared? A 100 percent prepared is the ability to accomplish the capabilities. If you drank your coffee you'll realize they are not numbered correctly, you're right. They're not numbered correctly because they blend in with the Public Health Emergency Preparedness (PHEP) capabilities from our CDC colleagues.

So number 15 volunteer management is a capability that both the Hospital Preparedness Program and the Public Health Emergency Preparedness Program is moving towards. An important point, we have fundamental capabilities that are aligned between healthcare and public health from the viewpoint of preparedness and heath response. So that's an important message.

Our coalitions are primary care, acute care hospitals, EMS, long-term care, public health agencies coming together, working together so that they can affect care and better outcomes in disasters. They stand on four pillars. Daily delivery of care, they need to be completely functional.

They need to address risk and have to have some sort of views to what percent of population covered. If you anticipate that percent population covered is 100 percent and you drop functionality, then there's some pros and cons that that each awardee in each state has to come to grips with.

So what are our two program measures? You either affect change in three ways. You fund it, you measure it, or you do both. So in the Hospital Preparedness Program, we have changed.

The two fundamental programs are can you keep your doors open and your lights on and continue to operate and then can you medically surge? And those were the two key performance measures moving forward for the Hospital Preparedness Program.

We all know this EKG and if you don't, I'll let you know. This is a patient who is dying. He's dying of acute myocardial infarction. CMS and their colleagues at Joint Commission did something right and changed the nation.

They changed the nation with regard to acute care capabilities for cardiology. One measure, door-to-balloon time of 90 minutes integrated and coordinated and forced the coordination of EMS, emergency care, cardiology, and hospital administrations to deliver care to this patient appropriately within 90 minutes.

And certainly, a lot of literature out there suggests -- and I'm not a PowerPoint ranger because it's at the bottom of the slide -- those quotes are from a 2001 Circulation article that substantiates the fact that looking at from 2005 to 2010, there have been some significant successes in the area of acute - of the care for acute myocardial infarction.

So what did the Hospital Preparedness do? The Hospital Preparedness Program shifted to one measure, in addition to those program measures that we defined, to one measure to help encourage better medical surge. And that is the concept of Immediate Bed Availability.

Twenty percent of staffed beds within four hours of the disaster,. Not on top of, within. It is evidence-informed based on Gabe Kelen's work out of 2006, secondarily validated in 2009 and used in events like West Texas. It's operationally tenable. The usual board - the usual length of stay in a hospital is about 4.9 days, about 20 percent of the offload happens every day.

It's an economically sustainable model. It's put within the daily delivery system. It's ethically grounded and it perfectly blends with the Institute of Medicine's Crisis Standard of Care work.

For those who are graphically oriented, this is the way it is used to be, this is the way we want to achieve during a disaster.

Again, a graphic to help. Within four hours, we want that to happen and our coalitions to achieve that benchmark.

How can we strengthen ASPR and CMS working together in partnership? We have differences. First of all from Congress, we have different oversight.

We use different language, cost, quality, access, survey and surge, Affordable Care Act. ASPR uses other acronyms, PPD-8, ESF-8, NDMS, HPP, and CIP. It's an acronym soup.

But the truth is, irrespective of oversight and in respect to the different language, there are some commonalities. We all want quality safe care for our patients, whether or not in a disaster or during daily delivery of care. We want cost effective care and we want innovation to drive the way we're going to be doing things.

So we're looking at that moving forward and that's one of the reasons why we're hosting these calls today. There are a CMS strategy and a HHS strategy and the red highlights some areas of integration or coordination or areas of synergy that the Hospital Preparedness Program has with CMS and HHS, just a few of them to name.

So there are opportunities for collaboration. I think is my last slide. There are general considerations. We'll need to think about how regulations and requirements do not limit the ability to save lives in disasters.

We want to consider payment models within disaster response. We want specific opportunities with regard to the community health needs assessment. It could potentially include preparedness items.

Medical homes and ACOs as they stood up - as they stand up - could be integrated with the healthcare coalitions that I spoke to or could further integrate and encourage their providers to think about preparedness and resilience concepts.

John is going to speak to some health IT resilient ideas and now I spoke to the ACOs and healthcare coalition's coordination and then lastly, I think there's opportunity

space so we could realize with what CMS knows about vulnerable population and what FEMA and ASPR need to know when a disaster does occur.

So I think there's a way forward. I think when you think about that evidence-based, population-based health principles what CMS already thinks about on a daily basis.

And with that, I'm going to turn it over to Dr. Shari Ling. Doctor?

Shari Ling: Thank you. Thank you, Dr. Marcozzi and Dr. Margolis.

So I'm actually delighted to be here as part of this conversation really to emphasize that this is an important start of the conversation that will assist in delivering better healthcare, achieving healthier populations and also helping to curve cost through quality improvement and through our efforts to be prepared.

So just by way of scope, as a reminder, as CMS remains the largest purchaser of healthcare in the world and is responsible for the care and keeping for a roughly one in every three Americans and that population is expanding and growing and becoming more heterogeneous with more heterogeneous needs, some of which represent a growth of a more vulnerable population. So what we talk about today on how we are better prepared and how we can prepare our system as providers to meet the service needs of this changing population is really quite an important conversation to engage in.

So as you all know, healthcare transformation is occurring. We are employing the critical components that are for transforming healthcare including quality measurement, aligning payment incentives, building on the best known evidence to do so, and also enabling and building out health information technology as critical infrastructure to achieve the three-part aim. And also making available quality improvement collaboratives, learning and action networks, and technical assistance to do so. All the while also recognizing that training and multidisciplinary teams of the how-to that Dr. Marcozzi just mentioned is a critical part of transforming healthcare at the frontline.

This picture simply depicts some of the policy and payment letters that are at our disposal that are under CMS and HHS authority to deploy. Some of these -- really all of these are grounded on the best available evidence but also focus on quality, that is

measurement of quality, reporting of quality, public reporting of quality, and venturing into the area of paying for higher value care rather than higher volume care Really keeping focus on better health outcomes for patients and for the population at hand.

Importantly, this also includes conditions of participation which describes the expectations for all provider facility types from hospitals to post-acute care to nursing homes and end-stage renal disease facilities that our surveyors then enforce.

We also have a mechanism to provide quality improvement and technical assistance as well as demonstration projects and new care models and new payment models that Dr. Marcozzi mentioned. All happening at different degrees to some extent across our county.

This depiction is just to highlight where I fit as the deputy chief medical officer in the Centers for Medicare & Medicaid Services within the Center for Clinical Standards and Quality that really is the home of most of the majority of quality efforts across our agency.

So in the next few minutes, I thought I would walk through a couple of points based on Dr. Marcozzi's comments and requests and what CMS's role is in playing effectively responding to and recovering from disasters. First of all, we will start with the 1135 waivers. I'll briefly walk through the conditions of participation flexibilities that do not require such waivers.

We'll also make the point of the expectations for providers and suppliers to be prepared and touch a moment on the technical assistance provided through our quality improvement organizations and with the exemptions from reporting penalties for currently implemented programs.

So just - as a way of just mentioning, we are fortunate to have some of our subject-matter and program experts on the phone and will be available to field questions at the end. Marilyn Doll and David Edinger and also Jean Shields are on the line joining me on this call today.

So the 1135 waivers, this is permitted under the section - in Section 1135 of the Social Security Act - the intent of which is to ensure that there's sufficient healthcare items and services that are available during a disaster to meet the needs of the

Medicare, Medicaid, and Children's Health Program beneficiaries, so really the population at large. Healthcare providers are really expected to provide services in good faith during a disaster and those services can be paid and are not subject to sanctions for non-compliance, absent any evidence of fraud or abuse.

There's a high threshold for the 1135 waiver so it requires either a presidential declaration of a national emergency or secretarial declaration of a public health emergency as depicted here in this slide.

This section authorizes the secretary to waive or modify certain Medicare, Medicaid or CHIP requirements in certain types of emergencies, generally coverage rules, payment rules, and rules applicable to beneficiaries may not be waived or modified. But that this is a federal authority and not under a state jurisdiction.

There's some examples that I provided here and just to highlight them and certainly are able to insert more detailed questions in the period following the presentation. There are conditions of participation, licensure for practitioners to provide services in affected states, the EMTALA requirements for authorities, Stark self-referral sanctions, Medicare advantage, out-of-network providers, and, of course, HIPAA.

Now, how long or to what duration would a waiver apply? Waivers end no later than the termination of the emergency period or 60 days from the waver date unless the secretary extends for added periods up to 60 days, up to the end of the emergency period. Likewise by EMTALA by law waivers are shorter in duration, approximately 72 hours after activation of a hospital disaster plan unless there's a public health emergency such as a pandemic.

There is a review process that is depicted here. Within a defined emergency area, a determination of need and expected duration needs to be stated and the question of can this be resolved within current regulations or if regulatory relief is requested actually addressed the stated need. And then, of course, should we consider a blanket or individual waiver.

The waiver inputs are multi-faceted, as you can see, and just to lay out the process or expectation of waived providers, a request must be made with sufficient information to actually justify the need. Providers and suppliers will be required to keep careful

records and documentation of beneficiaries to whom they have provided services under these circumstances to ensure that proper payments can be made.

And then the providers, of course, must resume compliance with normal rules and regulations as soon as they are able to do so. There are examples of actual waivers for EMTALA critical access hospitals and skilled nursing facilities with the applicable regulations as depicted here.

But in addition to 1135 waivers, there are Conditions of Participation flexibilities whereby no waiver is needed. Hospitals, for instance, can increase inpatient bed capacity under certain circumstances and it can also increase the outpatient capacity as depicted here and hospitals responsible for compliance with CoP must be maintained at all applicable sites.

Other flexibilities like Safety Code waivers are always permitted and to meet a community's needs CMS can make extended life safety code waivers available after the 1135 waiver has expired or where no 1135 waivers were issued.

So likewise, there are EMTALA flexibilities that permit evaluation and screening that is redirecting individuals to alternate sites or alternate campuses and use of off-campus hospital sites for screening.

Now, there are also some language for preparedness in current regulations that is critical access hospitals and hospitals required to have emergency power in waiting in key service areas as well as emergency fuel and water. But there will soon be proposed emergency preparedness requirements for Medicare and Medicaid participating providers and suppliers to ensure that they can adequately plan for both natural and man-made disasters and coordinate amongst federal state, tribal, regional, and local emergency preparedness systems.

So here, this is actually a rule that will be proposed to- that gets us in the direction of exactly what Dr. Marcozzi was pointing out as far as a system-wide approach to the need for preparedness. This rule would require providers to develop emergency plans, participate in training exercises, so not just to have a plan but to actually be prepared and train up to those needs.

As well as ensure providers and suppliers are adequately prepared to meet the needs of patients, residents, clients, participants during disasters and emergency situations. And this rule is due for release this calendar year.

Now moving on to the next section, just calling your attention to the fact that the quality improvement organizations actually fulfill the mission to improve the effectiveness, efficiency, and economy of the quality of services delivered to Medicare beneficiaries. This is the largest network - federal network - of providers across the country.

They are responsible for protecting beneficiary rights and preventing premature discharges or service terminations on behalf of beneficiaries. The goal here is to move towards improving outcomes and protecting beneficiaries at a local level, although the process is federally implemented, the QIOs operate on principles of convening, organizing, motivating, all-teach, all-learn sharing techniques that work and learning from examples, every example of a system failure. So this is a very, a real, and available mechanism to not only set expectations but to help train up and fill care gaps. Again, in support of improving quality across the country.

So I have pretty much covered this slide, but needless to say, this would be including and focusing on bold goals that require transformation at system level so you can see how this is very well aligned with Dr. Marcozzi's comments earlier.

Now how can QIOs operate in an emergency situation? QIOs have listserv access to a network of providers and have access to patient medical information as well. The learning and action networks are communication vehicles that can easily be used to rapidly spread important information.

And during the infection outbreak, this mechanism was used to ask QIOs to look for, mitigate, and prevent healthcare-associated infections through national calls and collaborations that at times included urgent communication.

QIO operational emergency preparedness capabilities also include assisting CMS public health efforts by disseminating information and messages rapidly, utilizing these networks of providers and partners for immunizations and other preventative health measures in the time of a urgent situation or an emergency. And can facilitate

effective discrimination of HHS information such as the ones -- the type of information that you are hearing today.

QIOs can also assist state health departments in provider education and ensure that state contacts remain current to ensure clear lines of communication, effective coordination, and that the message gets to the right people in the field, boots on the ground, participate as well in state disaster planning processes as well as actual implementation and technical assistance.

In addition, another example of the QIO activities might be to participate in state pandemic readiness committees as necessary to help bridge communication between mobilized physician practices, hospitals, nursing homes, ESRD networks, and the like.

As you can see, these are providers of different types that touch patients, population and communities. And subscribe to established listservs for emergencies disasters, pandemics and the like, all in the spirit and in preparation for readiness.

Now CMS has a variety of quality reporting programs and performance programs that span from hospitals that you've heard most about today all to way to physicians and post- acute care facilities as well as healthcare plans and communities and populations and has ventured into value-based purchasing in several areas.

One of which is end-stage renal disease facilities and also hospital value-based purchasing. And the value-based purchasing program really is a mechanism or vehicle for CMS to converge the concept of quality and payment.

And as you know, hospital-based value-based purchasing in the past year and the coming years really is rewarding for both attainment and improvement of hospital outcomes on a variety of clinical measures, of patient experience of care, efficiency, and avoidance of events such as healthcare-acquired or associated conditions.

So a given value-based purchasing is in the field, there has been concern and how-- so as not to penalize hospitals in the event of a national disaster, regional disaster or other circumstances when hospitals and other providers are really trying to do the right thing by taking care of the patients and families first.

So the CMS actually finalized the right to issue both blanket and individual exemptions from reporting program requirements due to extraordinary circumstance beyond the provider's control. Payment reductions can be waived when all annual program requirements are waived for the entire reporting period exempt program requirements of a specific time period, which varies in length. But that the providers must adhere to the requirements for the covering time periods that are not exempt.

There are specific criteria that include but are not limited to the following that the providers have ability to operate and care for patients in a setting, that access to normal level of public utility services is guaranteed, that FEMA disaster designation status of provider geographic areas and the availability of medical records that are needed to collect quality data, and in general, providers must submit the individual request through the quality net Web site within 30 calendar days following the extraordinary circumstance occurrence. So there is a release that can be requested through this mechanism.

So with that, I would like to turn the podium over to Mr. Lee Stevens. Lee?

Lee Stevens: Yes. Thank you very much.

Hi, this is Lee Stevens. I'm the director of the State HIE Policy Office and I have my colleague and Deputy Director, John Rancourt, is also on the line and we'll be doing a fairly thorough presentation for you.

I wanted to sort of kick this off by talking about particularly what we have been doing the past few days. I'm in Los Angeles where we have been meeting with emergency responders from across Southern California. Susan McHenry from DOT has also been here talking about National EMS Information System (NEMSIS) 3 and we're really looking at the power of Health Information Exchange and what we've done on the State HIE Program at ONC to make data move electronically.

We're really pleased with our success across the country. John can talk a bit more about that. We have 56 grantees and a majority of those, all 50 states and the District of Columbia and five territories, those all have operable Health Information Exchange now and this makes - it sort of opens the landscape for emergency response.

And also for consumers, for the patients themselves to take a bit more of a personal responsibility approach to preparedness and particularly in places like New Orleans

based on what had happened with Hurricane Katrina. And one of the priorities, we're doing the meeting I am currently attending in Los Angeles is the fact that we're in a high risk zone with earthquakes, floods, potential for tsunamis, and those kinds of events that could displace a large part of the population.

So we've talked a lot at this meeting about public awareness campaigns to encourage people to adopt personal health records that it will be required under Stage 2 meaningful use that starts in January. Providers across the country are required to share patient's records with them electronically. We're also talking a lot about creating interoperability between EMS providers and local health information exchange organizations. That can be a fairly complex task.

The State of California has 35 separate health information exchange organizations, and regionally, they are beginning the conversations to connect their first responders to those organizations. California is the first state to really tackle from a large scale this new opportunity for preparedness. And so it's very exciting to see it happening here. We've worked very hard across the southern states over the past few years and we have a number of states that have data sharing agreements for interstate exchange and have signed the memorandum of agreement that John will talk about a little bit later

But I just wanted to give everyone sort of a snapshot of what we've had going on at ONC and I'm sorry I'm going to have to sign off to check out of my hotel and head to the airport but I'm going to turn it over to John Rancourt and you will be in very good hands.

John Rancourt: Thanks, Lee, and I'll touch on some of those points that you've mentioned.

David Marcozzi: John, Dave Marcozzi. Just to interrupt for one second.

John Rancourt: Sure.

David Marcozzi: Just let us know when you advance slides, we're going to just take control for the slide deck from you, okay?

John Rancourt: Oh sure. Okay. So we wanted to start off just by introducing you all to ONC. This is a little bit of information about our mission which is to coordinate health information

technology and health information exchange efforts across the country and we do this in collaboration with other federal agencies, states and private sector entities.

And as you can see from the second bullet, ONC was originally created by an executive order under President Bush but then was legislatively mandated under the HITECH Act which was part of the Recovery Act.

So next slide, please. HITECH, as I said, was part of the Recovery Act and created the EHR Incentive Program commonly known as meaningful use. So if you're a hospital and you're on this call, you've probably heard of meaningful use and the incentive payments that are associated with it.

And if you're a state, then you probably know about meaningful use as well for this last bullet on the slide here, the $15 billion in incentive payments that have been made to date. About half of them roughly have come through state Medicaid programs.

But jumping back to the second sub-bullet here, CMS and ONC both play roles in this program. We work very closely and collaboratively on building health IT infrastructure with our colleagues at CMS.

But just so you can understand, CMS is the entity that establishes what are the requirements for being a meaningful user. And then ONC, we're the agency that establishes the criteria for EHR vendors, this is electronic health records, to be certified in order to meet those meaningful use requirements.

Next slide, please. The next slide, 72, and maybe it's not showing up on mine -- okay. Here we go. So this slide shows the various ONC programs that were created under the HITECH Act. In the middle, you can see the State Health Information Exchange Program which is the $564 million program that Lee and I work on. And our program has focused on building health information exchange capacity at the state level.

And what does that mean? It can mean a variety of different things. It can mean building capacity for electronic prescriptions. It can mean allowing for laboratory results to be exchanged electronically.

But it also can mean in general sort of two different frameworks for performing health information exchange. One is the, what we call query-based exchange. This is where you have established an information technology infrastructure that allows for EHRs to connect and then query one another for information. And this is highly valuable and important during disaster scenarios where you're looking to learn about potential patients that have come in or actual patients and what their medication history is, et cetera.

But also we've worked on building capacity for directed exchange or secure E-mail. And what that allows is for one doctor to send a message to another about a particular patient, fully encrypted and secure, private. And to share information back and forth not in real time but just like you would through an E-mail message but through a secured channel. You can see the other programs we have here. Maybe we'll chat about some of them later.

Next slide, please. And if you can click through all the animation here, I'm actually going to skip this slide which just sort of describes how meaningful use is the sort of center framework for all the programs that we do here in ONC.

So this slide here is pretty important and this shows the meaningful use escalator which is the term we've used for this. But it's essentially the vision for the policy behind HITECH. And it shows roughly corresponding with each of the stages.

Meaningful use Stage 1 was primarily focused on capturing and sharing data whereas Stage 2 is focused on advanced care processes and decision support. And then ultimately stage three will be focused on trying to improve health outcomes. And that’s where we make the connection to - we begin to make the connection to health reform.

Next slide, please. And we often say that HITECH was a down payment on the Affordable Care Act and healthcare transformation. This slide sort of shows that in order to accomplish the triple aim of better health, better care, and lower cost and do that through these various care delivery innovations, consumer engagement like Lee mentioned, payment reform like through all those programs that are taking place at CMS. Really, a robust infrastructure of health information exchange and electronic health records as necessary in order to accomplish this.

Next slide, please. So actually I'm going to jump through - skip through these slides. You can go back and look at them. This just shows the impact that we're having through health information technology and the improvements made because of the Recovery Act.

So we can stop here and this sort of starts to get at where we are right now which many of you are probably pretty interested about. We're just about to enter into meaningful use stage two as Lee had mentioned in 2014. And these are two of the requirements that are built into the meaningful use program.

One is requiring syndromic surveillance reporting and the other is electronic lab reporting. And then another one that I don't think I have mentioned in these slides but is critically important is electronic clinical quality measure reporting and that meaningful use is going to require that meaningful users make those submissions to states and to the federal government.

Next slide, please. I wanted to talk a little bit about what ONC is doing specifically to support preparedness efforts and the best way to do that is to direct you all to this report that Lee and I had worked on with a variety of states. You see them listed here.

On a report on disaster preparedness that was focused on southeastern states because of the likelihood of a disaster happening there, probably a hurricane. And our goal was to develop a strategic plan for sharing health information across those states. To do this, we convened these states and worked through the difficult problems that are involved with both policy, technology, governance, and so on and so forth. And our sort of informal goal was to avoid the chaos that had occurred following Hurricane Katrina.

Next slide, please. And Lee mentioned some of that in his introduction. So we eventually created a final report which you can access through our Web site here and I encourage you to check it out.

Next slide, please. We -- or you can read about it through a journal article that we had published in August in the Annals of Emergency Medicine. And the key points that I'd like to make here were that we were trying to discuss the differences in responses to Hurricanes Katrina and Sandy and begin to posit that these - the

differences in how a response occurred were partially due to the prevalence of health information exchange and it's ability to be used.

But perhaps most importantly was not just that health information exchange was there, but that health information exchanges started to become part of the way we deliver everyday care in this country. And I know that Dr. Marcozzi has spoken frequently about this and mentioned it earlier that if we really want to improve care during a disaster, we need to improve care during everyday emergency situations which is anytime someone arrives in the emergency department. Information is critical and making sure that information is available then that's something that we're attempting to do through our programs.

Next slide, please. So the current status of health information exchange. This is really a rough overview. Our program is coming to an end. It was a Recovery Act Program and we are wrapping up. But we have seen -- and because of our program, we have seen significant growth in health information exchange capacity across the country in both those two models I mentioned earlier, query-type exchange systems but also directed exchange.

I think every single state in the country today has the capacity for directed exchange and we encourage you if you would like to learn more to reach out to us or reach out to your state departments that are focused on this. Most of them are in Medicaid. They are sort of different in every country if you're interested in learning more about getting access to that type of health information exchange.

And this last bullet sort of touches on that conundrum I was just talking about is that there is great variability in the exchange structures across the country.

Next slide, please. And this slide is just sort of a snapshot of how variable that exchange can be and how in flux it can be. In fact, I was just looking at this slide to go over since we submitted them last week.

Well, this didn't happen within the last week. It was an error in the slide but North Carolina has recently passed a law to require all hospitals in the state to be connected to their health information exchange. So we are seeing an upward trajectory in the capacity for health information exchange across the country.

Next slide, please. And that's really what we're very excited about is that trajectory and what it can mean for future technologies and the future things that can be done because of the technology that is becoming more and more prevalent due in large part to the HITECH Act. And this is one example of that is what we call real-time patient tracking and it's really based on some of the most basic information available and that what are called ADT feeds. Many of you are probably familiar with this.

These are admission, discharge, and transfer feeds that occur within an electronic health record system. It sends messages between different systems just to alert those different systems as to whether an admission or a discharge has happened. And what we found is that these feeds which can include additional information such as patient diagnosis, et cetera. Those can be sent to a central system that can track these feeds and even in real time be able to display very helpful and informative maps.

Next slide, please, such as this one which was done by our grantee in the State of Maryland. It's kind of difficult to see here but you can see Baltimore there where it's showing the total inpatient admissions there but also down wrapping around Washington, D.C. These maps can be highly useful for emergency preparedness situations.

But they are also useful for variety of other use cases bringing it back to the main theme of this Webinar such as health reform. We've been interacting closely with our colleagues at CMS such as through the Pioneer ACO Program and have found that for those programs just to know where patients are at, that's critical for these new business models. And ADT feeds which can provide this alerting type of information for providers so they can know if their patient has been admitted to a hospital or discharged or where that has occurred that can allow for them to better manage those patients' care.

So I believe that's the last slide. Is there a next slide with our contact information? There you go. Please reach out to us if you have any questions and please check out our Web site and follow us on Twitter.

So thank you so much for the time. We're very happy to be able to share a little bit of information about ONC. And now I'll pass it over to Cat.

Catherine Oakar: Hi, thanks so much, John.

My name is Catherine Oakar and I'm in the Office of Health Reform here at HHS and I feel fortunate to kind of take up some of the call's time and so thank you to Dr. Marcozzi and Dr. Margolis for giving me a few minutes just to touch on kind of where we are with the marketplace.

I know folks that you've already heard and will hear are kind of diving really deep on some of the really important issues for the preparedness folks. And so I just wanted to kind of take a step back and kind of just give you a quick overview of where we are with the marketplace especially with the Web site as I know you touched so many lives and so I want to make sure that everyone is on the same page and is kind of aware of where we are and where we're heading.

So with folks I'm sure are aware in terms of the marketplace is really where folks who have traditionally been locked out at the market for insurance especially the individual and small group markets. They are going to go for coverage. And so folks who have been locked out or priced out or dumped out given that they have a preexisting condition or want to move or hope to change jobs or start their own business and a number of other reasons will go -- have always been kind of out of luck in terms of getting health coverage.

And so that's really what the marketplace is for and especially in kind of building on Medicaid expansion, we really see health reform as a huge opportunity to expand coverage of so many Americans. And so obviously, I know a lot of today's focus is on health IT and delivery system reform. Some really key parts of I'm sure preparedness efforts.

But also I wanted to just talk briefly about kind of what the expansion of coverage means for preparedness efforts and I know Dr. Lurie and Dr. Margolis have kind of talked about this in the past. So I'm going to kind of try to piggyback off of their brilliant talking points but also some of their insights.

And so when we think about the marketplace, obviously, coverage expansion is pretty huge. You know, there are millions of people that don't have insurance. And so with the marketplace and with Medicaid expansion state-by-state, we're really seeing when the number of folks who have insurance goes up we see better health outcomes.

We see more security of mind - security and peace of mind that folks are protected from financial ruin that they're protected and that they can get the care that they need when they need it. That they'll be able to go into a hospital or an emergency room, present their insurance card and be able to get care without having to go into medical bankruptcy to get it.

And so certainly, greater coverage leads to improved health, improved population health and better resilience I think in disaster events and even pre-events. So I think it's really an important piece of preparedness efforts. Perhaps, I'm sure it's not always on folk's radars, but I think this is kind of where we see preparedness fitting into the coverage expansion.

But then also it's important to know, and I know Dr. Lurie has talked a little bit about this in the past, the improved mental health and substance use benefits that are result of the law. So because of the law, 62 million Americans will have better coverage of mental health services and substance abuse benefits.

But they'll also have that coverage at peri-level, meaning that now they can have a benefit, mental health coverage and substance use coverage at the same level as a typical hospitalization or medical or surgical benefit. So that's huge, I think, for, you know, in terms of disaster preparedness and in handling disasters and ensuring resilience that folks can get not only the typical medical and surgical care that they need but also the mental health care that they may need as well.

So I wanted to use this opportunity just briefly to update you on kind of where we are with the Web site. Obviously, it's been in the news a little bit lately and so hopefully kind of alleviates any confusion about where we are and where we're heading. And then I'll leave it to my colleagues on the phone to kind of take it from there to conclude.

But obviously, unfortunately, the experience on healthcare.gov, the Web site, has been frustrating. Folks have had trouble creating accounts and even logging in. And others have received confusing error messages or have had to wait for really slow pages to load up or things are just not happening in a timely fashion.

And so we're certainly aware that the initial consumer experience of healthcare.gov has really not lived up to the expectations of folks. And so obviously, we're

committed to doing better and I will say, and I know we say this a lot, but the Web site is getting better every day.

And so even with the issues that we've had, we've seen folks enroll on the Web site. We've seen folks enroll via paper. We've seen them enroll over on the call centers.

I just wanted to reiterate that really the message that we're trying to ensure folks know is that they can still go on the Web site. They can still try the Web site. It's getting better and we're expecting it to work for the majority of folks by the end of November, but it's still working for a lot of folks now.

We are also encouraging folks to utilize other pathways to apply for coverage. I know we often focus so much on the Web site but there are other ways to enroll. So folks can obviously go online at healthcare.gov but they can also call on the phone. We have a call center that's available 24 hours a day, seven days a week and states regardless of whether they are a state-based marketplace or a federal marketplace, they all have call centers.

And so I'd encourage you, even if you have questions about what's kind of going on to call the call center and they can kind of talk you through where you may you need to go in terms of helping somebody enroll or you yourself enrolling or your patients or your consumers.

But they are also able to work with somebody trained in their local community and I'd imagine from just kind of seeing all the attendees on the line, the number -- I'm sure there are folks in your organizations that are part of that effort either as navigators or certified application counselors.

But if you're not aware and you'd like to point your patients or your consumers or those that you are interacting with to the right direction in terms of somebody in their local community, you can easily go on healthcare.gov and type in "find local help" and they will be able to find somebody in their community that will help them apply for coverage.

And so I just wanted to really reiterate that so you are aware that there are - there is very much a grassroots effort in terms of getting people to enroll. And I'm hopeful as many of you I'm sure folks in your organizations are aware, I'm hopeful that more and more organizations will join the effort.

It's not too late. We're really ramping up our efforts and increasing our work with partners, insurance providers, states, basically the whole gamut of folks that you would expect and some that you probably wouldn't expect. We're really trying to think outside the box in terms of our outreach efforts.

So I'm hopeful that many of you will join in the effort or at least tell folks that you interact with, I know you touch so many lives daily, to continue to use the Web site and to continue to see this as an opportunity to get the coverage that folks need.

Obviously, I don't have to tell a bunch of preparedness folks that you always need to prepare for the worst and so I know insurance is not always an easy sell but we always try to ensure folks realize that you never know what can happen and this is really kind of bringing peace of mind and security to many Americans.

And so I'm hopeful that you'll not only inform the many folks that you touched about healthcare.gov. I'm sure they may be confused, they may not realize that we're still trying to improve the Web site and that options will and are available to them. But I'm hopeful that you can iterate for us that they can still use it and that, you know, we're still moving forward. Obviously, we see this as really a tremendous opportunity to help folks and we're hopeful that you'll join us, if you aren't already, to help folks be as prepared as they can moving forward.

And with that, I will turn it over to our colleague in Oregon, Mr. Michael Harryman. Michael?

Michael Harryman: Yes, thank you very much, Cat. And I guess just to follow up on that, the word insurance, I often tell the story that I'm the - I am the preparedness insurance guy here in the State of Oregon and I have the honor of working with a great group of professional men and women both at the state local and tribal level to offer our resources through the federal government that we receive.

I am blessed to oversee both the Public Health Emergency Preparedness Program, the Hospital Preparedness Program, our MRC and volunteer programs and also over the last two years, we've been blessed to have a small cadre of AmeriCorps VISTA-young Americans working on activities such as wellness accreditation, preparedness and some EMS activities.

David Marcozzi: Hey, Mike Harryman.

Michael Harryman: Yes?

David Marcozzi: Marcozzi here. Do me a favor. Hit full screen, bottom left on your screen.

Michael Harryman: There you go.

David Marcozzi: Good to go.

Michael Harryman: All right. And so just real quickly, as Dr. Marcozzi mentioned earlier, you know, I'd like to try to connect some dots for you here at the state level, the capabilities and coalitions, performance measures, and the daily healthcare and the preparedness linkages.

Just so that you all understand, the State of Oregon was the ninth largest state in the state-- in the nation. We have a population of approximately 3.8 million. We're a home rule state. We have 36 counties, 34 local health departments, nine tribal nations, 62 hospitals and seven healthcare preparedness coalitions that I'll talk about in a little bit.

But I would be remiss with not talking about the Triple Aim. Under the leadership of our governor, John Kitzhaber, and our Oregon Health Authority, Dr. Bruce Goldberg, these two gentlemen are setting the pace and the tone within the State of Oregon for the Affordable Care Act and moving forward what you'll hear me use the term called CCOs, coordinated care organizations.

This is just a transformation of the healthcare system here in the state and everyday it's got a professional group of people working to make this happen.

We also have an accountability plan that we signed an agreement with the CSM, we, the State of Oregon, to improve the health care of the outcome.

And by saying that, I just want to briefly let you know the disclaimer. I'm not a subject matter expert on this particular area but I just felt like I needed to provide a few slides here and some talking points that how they are, we perceive them being connected in the future.

This is the map of our State of Oregon. These coordinated care organizations. These coordinated care organizations came online, 15 of them. There's 16 in the state now but there's 15 of them came on line one year ago, September of 2013.

This map will show the 16, the coordinated care organizations are a new way for the Oregon Health Plan that they will be an umbrella organization that governs and to administer care for Oregon health patient members and their local communities. This is a delivery system that covers people eligible for the Oregon Health Plan, Medicaid funds including those who are covered by Medicare.

CCOs must be accountable for the health outcome of the population they serve and then will have one budget that grows at a fixed rate for mental, physical and ultimate dental care. CCOs bring forward with new models of care that are patient-centered and team focused and they'll have flexibility within the budgets to deliver defined outcomes. They'll be governed by partnerships among healthcare providers, community members, and stakeholders in the healthcare system.

Well, in this state we're large but we have most of our members throughout the state are connected to one another and work together. So we have a big goal here, big mission here, but many times, many much of the same people that have committed to improve this stuff.

I think everybody that works in the world of preparedness have seen these two documents, these are the capabilities of both the HPP and the PHEP program and our goal is to blend these into the private sector model, not the private sector model blending in with us. This is not easy and we've been at it for many years across the nation and are continuing to.

These documents really did help us define some true capabilities that are important not only at the national level but also here at the state and local and tribal nation level and we have focused these capabilities all the time in our daily discussions and these are the things that we are ready to offer to our coordinated care organizations.

This is the state of Oregon a little bit different map. These are the seven -- we have seven hospital preparedness regions. In 2011, we converted them to the Healthcare Coalitions, the HCOs. This was mainly some focused guidance that we received from HPP back in the 2011 time period. These were already established.

In 1987, Oregon was one of the first states to establish the trauma system in the nation and these are the trauma regions also. So this is how the daily flow of patients with EMS and trauma works throughout the state. These borders in shaded areas, just gives you an idea, we have seven of these regions. We fund some staff out of the HPP program to work with these coalitions to do the day-to-day behind the scenes things with them and also to facilitate coalition meetings.

To date, what we have done is we've done regional hospital preparedness, regional vulnerability assessments, we've done local health assessments, and we work with our nine tribes to do tribal assessments. This has taken us about a year but we did this in co-injunction also with our Office of Emergency Management who also was working on threat assessments through their 36 counties through their local emergency management.

So we did not want counties to have to do these at different times. We were patient enough to wait and work with our Office of Emergency Management to ensure that when a county was going to do not only as public health, to focus on the public health and the mental pieces of a vulnerability assessment, they were also going to look at the threats, both man-made and natural disasters working with their public safety and their emergency management folks. And I got to tell you, this paid off in big dividends and are still paying off today.

Currently, we're working on gap assessments with the hospital coordination organizations with our coordinated care -- our tactic right now is patience. We're letting these coordinated care organizations focus on what they've signed a contract with CMS to do what they got to do. But behind the scenes, we're working with the other state staff that are also in the Oregon Health Authority on the tools that we have to offer when they're ready to talk to us.

Things such as business continuity, comprehensive membership, we have regional presence and the operational preparedness capabilities are there for them to use and let us help them help their clients.

Our primary focus for this current period has all been around surge management and surge management, the way I explain it to my staff and stakeholders is it encompasses everything from information sharing to EOC operations to volunteer management. It is the gap that we need to fill based on the hazards facing our state.

On this particular map, if you would look on the ocean side, the Pacific Ocean, we have a Cascadia subduction zone that runs from the Vancouver Island all the way to Northern California. And when it unzips someday, it's been 311 years since that last hazardous hit, it's going to not only shake the state but we'll have tsunamis that will immediately impact the state sometimes within 15 to 20 minutes once that event happens. The pre-planning we're doing at the local level with our healthcare and our hospital systems and our local health and emergency management to bordering states and our federal partners in Region 10, you know, just tell us that we have to stay on top of this.

These CCOs, they're doing day-to-day stuff and I'll leave you with a quote here in a little bit. I think what we're trying to do is connect these dots. But what we're trying to work on for the next 12 months is really focus on the target capability, the healthcare systems preparedness. You know, there are several functions within that that we offer to our healthcare coalitions to the CCOs of things that we bring to the table that we have proven, we've tested, we've trained, we've exercised and when we found things that we needed to fix, we fixed them or we're continuing to fix them to offer so that they have an understanding, they don’t have to start at scratch.

I'm excited about the rules that are going to be updated or proposed from CMS in 2014. That really does address a huge gap across the state and across the nation. And I just wanted to thank folks for doing that.

The next slide I'm going to show you is a slide I've used. I think maybe folks in the HPP world will recognize this. But this pretty much, the table comes out of the medical surge capacity and capability and management system for integrated medical and health resources during a large scale emergency. So I use this to talk to new employees, new leadership and new partners and sometimes even old partners.

And the wheel I designed is, in the middle is our state emergency management. They run this data emergency coordination center and the 15 ESFs. Obviously, we're the only state agency that does public health and medical services so we are the ESF-8 of the state.

The principles off to the side are just some of the things that keep me focused and my staff that we have state statutes that require us to be prepared and to do things and we also have to have a flexible system. This flexible system that I see with the hospital

preparedness organizations as they came online when we went from just a region to a coalition, really ties in between tier two and tier three.

Those particular things are where we are blending and still struggling and I can be honest with you that that the struggle is sometimes that the jurisdictions are the counties that's a -- we're a home rule state so, you know, healthcare organizations sometimes are in multiple counties or they stretch across a particular region and, you know, we need them to continue to work, to blend into the private sector and people understand and respect what they're trying to accomplish and how we can help them.

It's not always easy. Every stakeholder has a little bit different focus and what we do is try to blend those focuses together. But Marcozzi's slide on 17, talked about the healthcare coalition, this really helps me sell that.

Those healthcare coalitions, you know, are the primary thing for the capability preparedness is to focus on health resource assessments and coordination and then training and exercises. And we continue to work on that.

Also, on Slide 17, Dr. Marcozzi talked about immediate bed availability. The 20 percent and the four hours within a facility. This is a tactic that we totally endorse and what we like about this is we're not putting any extra stress on the hospital to increase by 20 percent but to use that multiplying factor of their staffed beds inside their hospital to take on the additional 20 percent in the four-hour period because something happened and we need that capability.

Also in Slide 21, Dr. Marcozzi talks about continuity of healthcare operations and medical surge. To me, this is probably the biggest dot that we at the state offer to our coordinated care organizations is that we are already doing this. We already have these things in place and by having these things in place or by working on them, when they're ready to talk to us to take that next phase, I think that they'll be very pleased at where we're at in the state and also to find that we're a willing partner.

And again, many of the people that are on their coalitions are also the same hospitals that we talk to. They're just different people within those organizations. And so, we're trying to connect those dots.

My next slide is just to kind of give you an idea. This is our critical infrastructure and key resource map. We just recently updated this but as you'll look at it, you know,

the legend's a tad bit hard to read but, you know, we have over 1,200 medical offices, we have 12 birthing centers, we have 40 school-based centers, we have 89 ambulatory service centers, 52 dialysis centers, the 34 local health departments, the nine tribal clinics and so on and so forth.

This is our bread and butter. These are our core partners that we need to connect to. They need information from us and we need information from them. And when a bad day happens, we need to be able to draw from them as much information as we can so we can articulate a situation not only to our governor but also to our federal partners of what we need, when we need it and where we want it.

And I want to just emphasize on Dr. Ling's slides, 34 and 46, I really do appreciate the fact that she covered the 1135 waivers, and then also, on Slide 52, the proposed rules. I learned something today about the QIO and I think I'm going to do some follow up with my counterparts here in Region 10 to learn more about that.

And I think the quote I like to leave is just here -- I've heard so many times traveling throughout the nation and the state, people talk about -- my staff know me and I like to connect the dots. I think people are dots, organization are dots and counties are dots and I always want to tell people I'm not that to insult them, I'm just - this is how I perceive it.

But our goal is to connect those dots with the healthcare stakeholders and systems and to find that sweet spot between the day-to-day healthcare delivery and response and recovery efforts when a bad day impacts our clients and the healthcare systems.

And with that, I'm going to turn it over to Dr. Margolis who's going to handle all the Q&As and I want to thank you for the opportunity. Thanks.

Gregg Margolis: Mike that was a really outstanding summary and we really appreciate you pulling everything together in such an elegant way towards the end of the session.

Operator, I'd like to ask you to give the participants instructions on how they may ask a question.

Operator: Ladies and gentlemen, if you have a question or a comment at this time, please press the star then the one key on your touchtone telephone.

Gregg Margolis: While you're thinking about asking a question, I do want to mention that we only have a few moments while we're together synchronously. But there is a mechanism by which you'll be able to ask a question via the Webinar.

If you simply type your question into the chat session, we will compile all of the questions that we receive and distribute to all meeting participants a set of answers to them so if we don't get to your question, we'll apologize in advance but make sure that you know that there is a way that you will get an answer to any of your burning issues.

With that, we did have a question during the presentation from Mike Vasner and I'd like to ask our colleagues from CMS Marilyn to address the question. What do you see as the incentives for non-hospital healthcare coalition members to participate with hospitals to accept non-acute patients from hospitals to let hospitals free up beds during an emergency? Marilyn?

Marilyn Doll: Well, that's quite a question. Obviously, in an emergency, we would hope that people are going to be pitching-in in order to provide the assistance that they're able to offer in terms of there being additional incentives, as Dr. Ling pointed out in her presentation, under the law that governs the 1135 waivers, payment requirements are not among the things that CMS is able to waive for Medicare requirements.

So a facility can certainly bill for the services it provides to patients that it would normally be able to bill for but if the question is whether or not it has an ability to bill for something different or unique or an atypical service set that it's providing, I think the answer is no.

I do want to say that perhaps we should also develop a written response to this because we don't have our colleagues from the payment side of Medicare on the phone and so we always get a little bit hesitant to venture too much of an opinion about payment policy.

Shari Ling: And this is Shari. I would concur. We would be happy to look into this further with our payment colleagues because it is a little complex. One would think that this would be similar to a post-acute care stay. However, there are, you know, there's a duration that's required in the acute hospital so, you know, we would have to look into this further. But thank you for the question.

Gregg Margolis: On that, I'll pause for a second and see if there are any questions from the group. Again, following your instructions from the operator.

Operator: Our first question comes from Linda Scott.

Linda Scott: Yes, hi. Thank you for excellent presentations. My question is for Dr. Ling and I'm in Michigan and as we look at moving forward our planning for alternate care site and some of the other areas where we know we might have to search our healthcare system, who within our state program would you recommend would be the best place to start when we're looking at things because the questions always come up about the ability to put patients and I'm not talking about state regulations or licensure but really more about those challenges that link to CMS. Where would be the best place to start within our own state programs?

Shari Ling: Great, so yes, thank you for the question.

I think the best place to start really would be with our quality improvement colleagues. You know, that, it would help us understand what the obstacles are at hand that you are anticipating and also likely have had experience addressing this with other colleagues or other systems or communities already. So probably, that would be the place to start. And if you send me an E-mail, I am happy to help forward that to the right contact person so that you're not wandering around through the electronic CMS system.

Linda Scott: That would be great. Thank you.

Gregg Margolis: I think we have time for one more question.

Operator: Our next question comes from Fred Petersen.

Fred Petersen: Good afternoon. A quick comment and a question please. The question is can we get a site or a reference on the CMS pending rule or regulation so that we can review it?

Shari Ling: Yes. It will be published. It is not - it's not out there yet. But it is one that we can circulate through our listserv as soon as we have a link for that.

David Marcozzi: Thanks for the question. Marcozzi. Dr. Ling will send it over to us and we'll send it out to everyone who's on this call today.

Fred Petersen: Thanks, Dr. Marcozzi.

And then a comment I'd make is that if you talk to any hospital administrator or CFO now, they want to talk about cash. Cash is king. And that's measured in two ways, generally. Cash flow and cash on hand.

And so while HIE is certainly important, so are EFTs, electronic fund transfers, and I just think that since we're on this topic, this is a great conversation today, but we've got to realize that the link between the payers and the providers is absolutely critical. The Darwinian process has taken out some of the weaker performers but there's still a lot of hospitals whose cash flow is critical. If that Medicare cash doesn't hit the bank, they may not hit their payroll.

So I would hope that in thinking about all of this in system restoration and in COOP planning that high on the list of critical infrastructure is the preservation or the reconstruction of the links for electronic transfers so that bills can be submitted and checks can be cut to keep the system going. Thank you.

Gregg Margolis: That's a great point and thanks for bringing it up. That was relatively short so I think we can take one more question.

Operator: Our next question comes from Carl Schmidt.

Carl Schmidt: Hi. Thanks for the time and great job today, guys.

Quick question. You know, Dr. Marcozzi talked about, there's kind of a triangle between policy science and emergency operations and when we look at the planning capabilities from both healthcare and for public health, there's a triangle that is, you know, emergency management public health and healthcare.

Working with healthcare coalitions, how do we get them -- somehow healthcare coalitions have to connect with the local emergency management system potentially at some point. Do you guys see that, you know, that there's going to be a natural divide between public health and healthcare coalitions or do you see them being almost synonymous coming together?

David Marcozzi: Yes, I'll take the fastball. I appreciate it – hey, thanks. This is Marcozzi.

So first of all, we are certainly not even -- it's not part of our vocabulary anymore to have a divide between public health and healthcare. In fact, public health's one of the key -- you know, there's three key components of coalition development, emergency managers, public health and healthcare delivery, they need to be brought to the table. The only way we can really achieve success is if we're both successful public health and health care and truthfully, that would support the overall construct in response to – that emergency managers think about.

So first off, no, got to come to the table both in hand, both partners need to think about things slightly differently and let me give you the context to that, so healthcare delivery typically is a one-off patient. Every provider thinks about a patient that's in front them and I get that certainly. But clinicians need to think about things slightly differently from a population health standpoint which is sometimes difficult for clinicians to consider.

In addition to that, our public health colleagues can also consider how - what their - what the priorities are for public health and population health, how they need to be thought about from the context of one-on-one primary care clinical delivery -- or not, pardon me -- from clinical delivery. And in addition to that, how their guidance or how our guidance affects the private sector market and how the private sector market will view federal guidance that’s based in the population or public health standpoint.

So those are two tensions that we recognize, that need to be brought together further. I think the capabilities in line are a starting point. But in truth, when we're looking at coalitions from the hospital preparedness program, we're looking to make sure that public health and emergency management are brought to the table. If they're not, then we have concerns about the ability of that coalition achieve success

Thanks.

Carl Schmidt: Thank you. Thank you.

Gregg Margolis: Well, there's great robust conversation here and we'd love to be able to continue but we want to be respectful of time. We will keep the Web site open for another 15 minutes. So everybody should be able to enter your questions via the chat session. We will compile those questions, get all of them answered and distribute them to all of the participants of this call.

At this point, I'd just like to take an opportunity to thank all of the presenters and all of you who have taken time out of your busy day to think a little bit about preparedness in the context of our rapidly evolving healthcare system and thank everybody for their commitment to improving our national health security.

Have a nice day.

Operator: Ladies and gentlemen, this does conclude today's presentation. You may now disconnect and have wonderful day.