

National Healthcare Preparedness Programs (NHPP) Healthcare Reform and Preparedness Webinar and National Call

November 21, 2013
2:00 PM – 3:30 PM EST

I. Welcome and Overview

– Dr. Gregg Margolis, Director, Division of Health System Policy, Department of Health and Human Services (HHS)

Dr. Gregg Margolis welcomed the attendees to the Healthcare Reform and Preparedness Webinar. The next decade is going to be the most dynamic in the history of the American healthcare system, due to the implementation of the Affordable Care Act, but also due to a variety of other factors influencing the healthcare system. The Healthcare Reform and Preparedness Webinar brings together a number of experts in the field to share some of the trends and issues that will be impacting the healthcare system. The session will also help the nation prepare for the future by understanding the impact that healthcare reform will play on preparedness.

In the book “Five Days at Memorial,” physician and Pulitzer Prize winning journalist Sheri Fink presents a gripping account of what happens when caring, compassionate healthcare professionals are forced to make impossible decisions due to a lack of preparedness. A quote from the book that highlights the importance of preparedness reads, “It’s hard for us to know how we would act under terrible pressure, but at least we have the luxury to picture in advance how we would want to make those decisions.”

The speakers on this call will help us prepare for the future by understanding the impact that healthcare reform will play on preparedness. Today’s speakers include:

- Dr. Shari Ling, Deputy Chief Medical Officer for the Centers for Medicare and Medicaid Services, will discuss the impact of payment and reimbursement, the changing infrastructure for reimbursement, and aligning incentives.
- Lee Stevens, Director of the State Health Information Exchange, and John Rancourt, program analyst, both from the Office of the National Coordinator of Health Information Technology, will discuss the role of health information exchange in the transition of our healthcare system.
- Ms. Catherine Oakar, from the Office of Health Reform, will discuss the impacts of the Affordable Care Act and provide an update on the website.
- Mr. Michael Harryman, Director of Emergency Operations for the Oregon Health Authority, will provide a perspective on how health reform is impacting state preparedness systems.

II. Healthcare Preparedness and Response: Healthcare Coalitions, Immediate Bed Availability and Aligning with Accountable Care Organizations

– Dr. David Marcozzi, Division Director, National Healthcare Preparedness Programs, HHS

Dr. David Marcozzi thanked the speakers and participants for coming together to have this national call. The goal is for this information to start to shape how people deliver healthcare now and during disasters. It is important to weave a thread of preparedness within daily delivery of care.

ASPR blends three different worlds: science, policy, and emergency operations.

- Science: ASPR is the home for BARDA which supports the development of appropriate countermeasures to public health emergencies and incentivizes the pharmaceutical and research industries to better produce the right pill for disasters when they are needed.
- Policy: ASPR has a policy agenda. In many instances, policy and preparedness blends with policy and daily delivery of care.
- Emergency Operations: This is largely supported by our NDMS colleagues, who are out there doing the job and who are on the call here today.

ASPR looks at events like the Boston Marathon Bombing and Hurricane Fran to identify how we, as a nation, can better respond to and prepare for no-notice, large-scale, and other events. As Dr. Lurie has stated, “If we can’t do it today, then we can’t do it on game day.”

It is important for the public and private sector to blend their preparedness efforts and HPP encourages that process. However, this is still a challenge because our healthcare system is complex and evolving. It resides predominantly in the private sector and quite often the public sector mission does not blend with private sector priorities. When it comes to medical surge, the concept of staffed beds waiting around for patients to fill them conflicts with the ideas of mission versus margin, the just-in-time supply chain, and just-in-time staffing principles required for daily operations.

The reality is that preparedness grants make up a fraction of the overall \$2.8 trillion that’s spent on national healthcare expenditures. The Hospital Preparedness Program is a \$350 million program currently and the present budget and has it listed at \$255 million coming up for 2014.

Hospital emergency departments are known to be a safety net and they often act as litmus paper because they predict how things are evolving. When emergency departments get stressed, healthcare systems are potentially stressed. The number of emergency departments closing their doors is an indicator of stressed healthcare systems. Interestingly, even though the number of emergency departments is declining, the number of emergency department visits is increasing.

Coalitions are working toward 100 percent preparedness by accomplishing all of the HPP Capabilities:

- Capability 1: Healthcare System Preparedness (Healthcare Coalitions)
- Capability 2: Healthcare System Recovery
- Capability 3: Emergency Operations Coordination
- Capability 5: Fatality Management
- Capability 6: Information Sharing
- Capability 10: Medical Surge (Immediate Bed Availability)
- Capability 14: Responder Safety and Health
- Capability 15: Volunteer Management

The numbering of the HPP Capabilities is not sequential because they have been aligned with the Public Health Emergency Preparedness (PHEP) Capabilities. There are fundamental Capabilities that are aligned between healthcare (HPP) and public health (PHEP) from the viewpoint of preparedness and health response.

But the truth is, if the mission versus margin ratio is contracting and a just-in-time supply chain is moving the nation away from capacity, then we are potentially moving away from preparedness and not towards it. It is important to blend and integrate preparedness activities with current health delivery methods to achieve 100% preparedness. To achieve this, the nation needs:

- A comprehensive national preparedness and response healthcare system that is scalable and coordinated to meet local, state and national needs
- A dual use application to preparedness integrating and improving the efficiencies of daily healthcare delivery
- A financially sustainable approach to preparedness
- A population-based healthcare delivery model for disaster response
- Defined healthcare preparedness capabilities and performance measures

Healthcare Coalitions (HCCs) are made up of acute care hospitals, EMS, specialty and primary care providers, long term care facilities, behavioral health, public agencies, private organizations, and others coming together to affect care and produce better outcomes in disasters. Coalitions stand on four pillars—daily delivery of care, percent of population covered, functionality, and risk.

The 2013 NHPP Performance Measures include:

- **Continuity of Healthcare Operations:** The healthcare entity would identify and mitigate risks, engage in preparedness and planning activities, develop effective response strategies and techniques, and engage in short and long-term recovery planning to facilitate an effective and efficient return to normal healthcare delivery operations.
- **Medical Surge:** Medical surge is the capability to rapidly expand the capacity of the existing healthcare to provide triage and subsequent medical care during incidents that severely challenge or exceed the normal medical infrastructure of the community.

CMS and the Joint Commission developed a standard of care for myocardial infarction patients that required that patients undergo a cardiac catheterization within 90 minutes of arriving at a healthcare facility. In the model of the 90 minute “door-to-balloon” standard, HPP moved to an Immediate Bed Availability (IBA) measure to help encourage better medical surge capability. This requires that hospitals demonstrate the ability to deliver appropriate levels of care to all patients and provide 20% immediate availability of staffed beds, within four hours of a disaster. This can be demonstrated through an exercise or a real incident. This is not on top of existing staffed beds, but within the facility. The IBA concept is evidence-informed, operationally tenable, economically sustainable, ethically grounded, and it perfectly blends with the Institute of Medicine’s Crisis Standards of Care Work.

There are ways that ASPR and CMS can strengthen their partnership. Although ASPR and CMS have differences in budget, Congressional oversight and language, there are some common desires:

- Quality, safe care for patients, whether in a disaster or during the daily delivery of care
- Cost effective care
- Innovation and technology to improve care
- Encouraging providers to work together to improve outcomes
- Bundled payments

A matrix of CMS and HHS strategies shows potential areas of integration/coordination/synergy that include:

- Improve quality and patient safety
- Foster innovations to create shared solutions
- Promote meaningful use of health information technology
- Promote sustainability
- Promote the safety, well-being, resilience, and healthy development of children and youth

- Improve the accessibility and quality of supportive services for people with disabilities and older adults
- Infrastructure and technology improvements enhance interoperability and promote evidence-based decisions
- Data standardization and integration effectively improves care coordination, performance, transparency, and knowledge discovery
- Ensure health care workforce can meet increased demands

These opportunities for collaboration require some general considerations:

- Ensure regulations/requirements do not limit the ability to save lives in disasters
- Consider payment models within disaster response

Medical homes and Accountable Care Organizations (ACOs) could also be integrated with the healthcare coalitions to further integrate and encourage their providers to think about preparedness and resilience concepts. Some specific opportunities include:

- Community Health Needs Assessment include preparedness concept(s)
- Medical homes and ACOs encourage patient preparedness
- Resilient Health Information Technologies
- ACO and HCC coordination
- Vulnerable population locations

Going forward, it will be important to strengthen our nation's healthcare system and to fully integrate disaster preparedness into the daily delivery of care. To achieve this we must build a resilient healthcare system that is balanced—assuring a patient-centered focus while prioritizing evidence-based, population-health principles.

III. Centers for Medicare and Medicaid Services (CMS) and Preparedness: Regulations and Waivers in Disasters

– Dr. Shari Ling, Deputy Chief Medical Officer, CMS

Dr. Shari Ling noted her enthusiasm for being part of this conversation that will help assist in the delivery of better healthcare, achieving healthier populations and helping to curb cost through quality improvement and through our efforts to be prepared.

CMS is the largest purchaser of healthcare in the world and is responsible for the caring and keeping for roughly one in every three Americans. This population is expanding and becoming heterogeneous with more heterogeneous needs, some of which represent the growth of more vulnerable populations. This discussion will focus on how we are better prepared and how we can prepare our system as providers to meet the service needs of this changing population.

As part of the healthcare transformation that is occurring, CMS is employing critical components 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.

CMS is focused on achieving better health outcomes for patients and for the population using the best available evidence and a focus on quality—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. Importantly, this includes conditions of participation, which describe the expectations for all provider facility types from hospitals to post-acute care to nursing homes and end-stage renal disease facilities that CMS surveyors then enforce. CMS also has a mechanism to provide quality improvement and technical assistance as well as demonstration projects, new care models and new payment models, as Dr. Marcozzi mentioned. This is all happening at different degrees across the county.

CMS plays a role in response and recovery through the following:

- **1135 Waivers**

1135 Waivers were permitted under section 1135 of the Social Security Act and the purpose of the waivers is to ensure that sufficient healthcare items and services are available during a disaster to meet the needs of Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries. It is also intended to ensure that healthcare providers that deliver services in good faith during a disaster can be paid and are not subjected to sanctions for noncompliance, absent any fraud or abuse.

There is a high threshold for granting 1135 Waivers. It requires either a Presidential declaration of National Emergencies Act or Stafford Act or a Secretarial declaration of a public health emergency under Section 319 of the Public Health Service (PHS) Act. Section 1135 authorizes the Secretary to waive or modify certain Medicare, Medicaid or CHIP requirements in certain kinds of emergencies. Generally, coverage rules, payment rules, and rules applicable to beneficiaries may not be waived or modified. This applies to federal requirements only, not state licensure.

Some examples of requirements that may be addressed in an 1135 Waiver include:

- Conditions of participation
- Licensure for practitioners to provide services in an affected state
- Emergency Medical Treatment and Active Labor Act, but only for
 - Sending folks for screening to off-campus sites
 - Transferring individuals with unstable emergency medical conditions
- Health Insurance Portability and Accountability Act (HIPAA)
- Stark Self-Referral Sanctions
- Medicare Advantage out of network providers

Waivers end no later than the termination of the emergency period or 60 days from the waiver date, unless the Secretary extends for added periods up to 60 days, up to the end of the emergency period. EMTALA waivers, by law, are much shorter in duration. They extend for 72 hours after activation of the hospital's disaster plan, unless the public health emergency is a pandemic infectious disease.

The 1135 Waiver review process requires that, within a defined emergency area, the actual need and the expected duration needs to be addressed. Then the reviewer must ask if this can be resolved within current regulations and if the regulatory relief requested will actually address the stated need and if a blanket or individual waiver is most appropriate. Requests must contain sufficient information to 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. Providers must also resume compliance with normal rules and regulations as soon as they are able to do so.

- **Conditions of Participation (CoPs) Flexibilities Not Requiring 1135 Waivers**

Not all CoP adjustments require waivers.

- Hospitals can increase inpatient bed capacity
 - If current number of certified beds exceeds maintained beds, no CMS review required
 - Increases above the number of certified beds – file 855A with MAC as soon as possible; no surveys or other CMS actions
- Increasing outpatient capacity
 - Add sites on the main campus without notice to CMS; could include tents (for short periods only), parked mobile units
 - Add off-site locations – file 855A as soon as possible
- Hospital is responsible for compliance with CoPs at all sites
- Life Safety Code (LSC) waivers are always permitted
- To meet community needs, CMS can make extended LSC waivers available after 1135 waivers expire, or where no 1135 waivers were issued (e.g. extended operation of limited hospital services in military-style temporary facilities while a hospital destroyed in a storm is rebuilt)
- EMTALA flexibilities permit evaluation and screening that redirects individuals to alternate sites or alternate campuses and use of off-campus hospital sites for screening

- **Requiring Providers/Suppliers To Be Prepared**

There are existing preparedness regulations that require critical access hospitals and hospitals required to have emergency power and lighting in key service areas as well as emergency fuel and water.

CMS is now developing proposed emergency preparedness requirements for Medicare and Medicaid participating providers and suppliers to ensure that they plan for both natural and man-made disasters and coordinate with Federal, State, tribal, regional and local emergency preparedness systems. This proposed rule will take a system-wide approach to preparedness. It will require providers to develop emergency plans and participate in training exercises. It would also ensure providers and suppliers are adequately prepared to meet the needs of patient, residents, clients, and participants during disasters and emergency situations.

- **Quality Improvement Organizations (QIOs)**

The mission of the QIO program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. QIOs are the largest federal network dedicated to improving the health quality at the state level. They are responsible for protecting beneficiary rights including preventing premature discharge or service termination and ensuring beneficiaries receive quality healthcare.

In an emergency situation, QIOs utilize listserv access to a network of providers and have access to patient medical information as well. The learning and action network communication vehicles can easily be used to rapidly spread important information. Also, during previous infection outbreaks, the QIOs used their Healthcare-Associated Infection National calls and collaborations to communicate urgent information. The Healthcare Communities website is another internal

vehicle that can be used for spreading information. In addition, the QIO may participate in the State's pandemic readiness committee(s) to help bridge communication between mobilized physician practices, hospitals, nursing homes, home health agencies, and end-stage renal disease (ESRD) networks.

- **Quality Reporting and Performance Programs**

There are a variety of quality reporting programs and performance programs that span from hospitals to physicians and post-acute care facilities as well as healthcare plans and communities that have ventured into value-based purchasing in several areas. An example of value-based purchasing would be end-stage renal disease facilities. The value-based purchasing can be seen as a mechanism or vehicle for CMS to converge the concept of quality and payment and it 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.

CMS finalized the right to issue both blanket and individual exemptions from reporting program requirements due to extraordinary circumstances beyond the provider's control. Payment reductions can be waived when all annual program requirements are waived for the entire reporting period. It also exempts program requirements for a specific time period and providers must adhere to requirements covering time periods not exempted.

The criteria to be evaluated include but are not limited to:

- Providers' ability to operate and care for patients in a specific setting
- Access to normal level of public utility service
- FEMA major disaster designation status of providers' geographic area
- Availability of medical records needed to collect quality data

Providers must generally submit individual waiver requests to CMS through the QualityNet website (www.qualitynet.org) within 30 calendar days following the extraordinary circumstance occurrence.

IV. Health Information Technology and Health Information Exchange During Disasters

- Mr. Lee Stevens, Director, State Health Information Exchange Policy Office, Office of the National Coordinator for Health Information Technology (ONC), HHS
- Mr. John Rancourt Program Analyst, ONC, HHS

Lee Stevens

Mr. Stevens and Mr. Rancourt are currently in Los Angeles meeting with emergency responders from across Southern California along with Susan McHenry from the Department of Transportation. The discussion has centered around the National EMS Information System (NEMSIS) 3 and the power of Health Information Exchange and what has been done on the state HIE Program at ONC to make data move electronically. Achievements have been demonstrated in that 56 grantees have operable Health Information Exchanges, opening the landscape for emergency response.

There has been a focus on the consumers/patients in high risk areas to take more responsibility for their own preparedness. This includes public awareness campaigns that will encourage people to adopt personal health records. Under Stage 2 Meaningful Use that starts in January, providers across the country will be required to share patients' records with them electronically.

There is also much discussion surrounding creating interoperability between EMS providers and local health information exchange organizations. The state of California had 35 separate health information exchange organizations, and regionally, they are beginning the conversations to connect their first responders to those organizations. Several southern states also have data sharing agreements for interstate exchange and have signed the memorandum of agreement.

John Rancourt

The ONC mission is to coordinate health information technology and health information exchange efforts across the country in collaboration with other federal agencies, states and private sector entities.

The ONC was created by an executive order under President Bush but was legislatively mandated under the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was a part of the Recovery Act and created the Electronic Health Record (EHR) Incentive Program, commonly known as Meaningful Use. Meaningful Use is well known for the \$15 billion in incentive payments made to date, about half of which have come through state Medicaid programs. CMS and ONC both play roles in this program and work closely on building health information technology (IT) infrastructure: CMS establishes requirements for being a meaningful user and ONC establishes the criteria for EHR vendors to be certified in order to meet the requirements.

Several ONC programs were created under the HITECH Act. The State Health Information Exchange Program, a \$564 million program focusing on building health information exchange capacity at the state level, is our focus. There are two different frameworks for performing health information exchange:

- Query-based Exchange is where an information technology infrastructure allows for EHRs to connect and then query one another for information. This is valuable during disaster scenarios to learn about a patient's background i.e. medication history.
- Security E-mail allows for one doctor to send a message to another about a patient, fully encrypted, private, and secure.

The Meaningful Use "escalator" is the vision for the policy behind HITECH. Meaningful Use Stage 1 is focused on capturing and sharing data. Meaningful Use Stage 2 is focused on advanced care processes with decision support, and Meaningful Use Stage 3 will be focused on improved outcomes, which is where one begins to see the connection to health reform. Currently, ONC is about to enter Meaningful Use Stage 2 and there are two requirements that are built into this program: requiring syndromic surveillance reporting and electronic lab reporting. Additionally, electronic clinical quality measure reporting submissions to states and the federal government will be required.

ONC published a report on disaster preparedness that was focused on southern states because of their high-risk environments. The goal was to develop a strategic plan for sharing health information across those states and to avoid the chaos that occurred following Hurricane Katrina. The process involved convening state participants to work through the difficult problems that are involved with policy, technology, governance, etc. The report focused on the different responses during both Hurricane Katrina and Hurricane Sandy and how those responses differed. It posited that the differences in how a response occurred was partially due to the prevalence of health information exchange and its ability to be used. It showed that health information exchange has begun to become part of the way we deliver every day care in this country.

There has been significant growth in health information exchange capacity across the country in both Query-based Exchange and Security Email systems and there is great variability in the exchange structure across the country.

There is also an upward trajectory in the capacity for health information exchange across the country. This upward trajectory can mean good things for future technologies in the health sector. For instance, real-time patient tracking, based on admission, discharge, and transfer (ADT) feeds that occur within an electronic health record system can now include additional information such as patient diagnosis. This information can be sent to a central system that can track these feeds and, in real-time, display helpful and informative maps. The ability to map out where patients are located is critical for new business models and enhances the ability to manage those patients' care.

V. The Health Insurance Marketplace: Update & Implications for Preparedness

– Ms. Catherine Oakar, Director of Public Health Policy, Office of Health Reform, HHS

The Health Insurance Marketplace is for those individuals who have had a difficult time getting health coverage, i.e., people with pre-existing conditions, people who move or want to change jobs, people that want to start their own business, etc. They see health reform as an opportunity to expand coverage for these Americans by focusing on Medicaid expansion. This expansion of coverage means better health outcomes, more security of mind that people will be protected from financial ruin and that they can get care when they need it. Greater coverage leads to improved health, improved population health, and better resilience in disaster events and even pre-events.

As many already know, there have been problems with the healthcare.gov website including issues creating accounts, logging in, and random error messages. However, the website is getting better every day and it is expected to work for everyone by the end of November. People don't have to use the website to enroll. They can also enroll via paper or through the call center that's available 24 hours a day, seven days a week, regardless of whether it is a state-based marketplace or a federal marketplace.

Encouraging people to enroll is a grassroots effort and, hopefully, more and more organizations will join the effort. Participants on today's call are encouraged to spread the word about healthcare.gov.

VI. State Promising Practices: Oregon's Preparedness Efforts Linked to Daily Delivery of Care Models—A Path Forward

– Mr. Michael Harryman, Director of Emergency Operations, Oregon Health Authority, Public Health Division

Michael Harryman oversees the Public Health Emergency Preparedness (PHEP) program, the Hospital Preparedness Program (HPP), and the Medical Reserve Corps (MRC) and volunteer programs for the state of Oregon.

Oregon is the 9th largest state in the nation. It has a population of approximately 3.8 million and it is a home rule state. There are 36 counties, 34 local health departments, nine tribal nations, 62 hospitals and seven healthcare preparedness coalitions. Through its proactive leaders and coordinated care organizations (CCOs), Oregon strives to achieve the "Triple Aim" of:

1. Better health for the population
2. Better care for individuals

3. Lower cost through improvement

Oregon currently has 16 CCOs, and these organizations cover people eligible for the Oregon Health Plan, Medicaid funds, and Medicare. Each CCO is accountable for the health outcome of the population it serves, and they bring new models of care that are patient-centered and team focused. The CCOs are governed by partnerships among healthcare providers, community members, and stakeholders in the healthcare system.

Oregon's goal is to blend the HPP and PHEP program into the private sector model. The HPP and PHEP documents have helped Oregon define capabilities that are important at the national, state, local, and tribal level. Oregon likes to focus on these capabilities in their daily health discussions and will soon be offering them to their CCOs. Oregon was one of the first states to establish the trauma system in the nation and these trauma regions align with Oregon's seven Healthcare Coalitions (HCCs). The state funds staff through the HPP program to work with these HCCs.

To date, Oregon has done regional hospital preparedness, regional vulnerability assessments, local health assessments, and tribal assessments. They have looked at the threats, both man-made and natural in conjunction with public safety and emergency management staff and this approach has paid off. Oregon is working on gap assessments with their HCCs and coordinated care organizations. Tools focused on business continuity, comprehensive membership, regional presence, and operational preparedness capabilities will be made available to staff within the Oregon Health Authority.

Oregon's primary focus is all around surge management, which encompasses everything from information sharing to EOC operations to volunteer management. Surge management is the gap that needs to be filled based on hazards facing the state of Oregon. In order to avoid a catastrophic situation Oregon must pre-plan with their healthcare and hospital systems at the local level. They must also work with bordering states and federal partners in Region 10 on emergency management. Mr. Harryman is hopeful that the proposed CMS regulations discussed earlier in this call will further assist in addressing this gap across the state and across the nation.

Dr. Marcozzi's presentation relates directly to Oregon in several ways. Oregon fully endorses the immediate bed availability approach described by Dr. Marcozzi in that it does not put any extra stress on the hospitals to increase by 20%, but instead uses the multiplying factor of the staffed beds inside the hospital. The Oregon state preparedness programs have made great strides in continuity of healthcare operations planning and medical surge that will assist in their partnership with the CCOs.

Oregon's critical infrastructure and key resource map shows over 1,200 medical offices, 12 birthing center, 40 school-based centers, 89 ambulatory service centers, 52 dialysis centers, 34 local health departments, etc. These organizations make up Oregon's core partners that need to be connected.

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

VII. Questions and Answers

- **Question:** The question was directed to CMS. 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 allow hospitals to free up beds during an emergency?
 - **Answer:** Hopefully, in an emergency, people would be willing to pitch-in in order to provide assistance. Also, under the law that governs 1135 waiver payment requirements there are certain things that CMS is not able to waive for Medicare requirements. So, a facility can certainly bill within the services it provides to their patients, but if it is outside of their usual service offering there are other considerations. The question will be referred to a Medicare payment specialist for consideration.

- **Question:** (for Dr. Ling) Michigan is looking at moving forward with planning for alternate care sites 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? The questions always come up about the ability to place 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?
 - **Answer:** I think the best place to start really would be with our CMS quality improvement colleagues. It would help us understand what the obstacles are at hand that you are anticipating and also likely they 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 Shari Ling an email, she will be happy to help forward that to the right contact person so that you are not wandering around through the electronic CMS system.

- **Question:** Can we get a site or a reference on the CMS pending rule or regulation so that we can review it?
 - **Answer:** Yes. It will be published. It is not out there yet. But it is one that we can circulate through our listserv as soon as we have a link for that.

- **Comment:** 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 are 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, 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.

- **Question:** Dr. Marcozzi talked about, there's kind of a triangle between policy, science and emergency operations and when we look at the planning capabilities for both healthcare and for public health, there's a triangle that is emergency management public health and healthcare. Somehow healthcare coalitions have to connect with the local emergency management system

potentially at some point. Do you see 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?

- **Answer:** The word “divide” is not a part of the vocabulary anymore. They do not have or want a divide between public health and healthcare. In fact, public health is one of the key components of coalition development, and the only way to achieve success is if both public health and healthcare are successful. Healthcare delivery typically is focused on the individual patient. Every provider thinks about the patient that is in front of them. But the clinicians need to think about things slightly differently, i.e., from a population health standpoint. In addition, public health colleagues can also consider what their priorities are for public health and population health and how they should also think about health from a one-on-one primary care standpoint. It is important for both to come together to be successful in health preparedness.