*NATIONAL HEALTHCARE PREPAREDNESS EVALUATION PRESENTATION SUMMARY*

**Sandra Cosgrove, Moderator**

**Measuring Success Through Exercises/AAR**

**Wednesday, July 22, 2009**

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**About The Speaker-** Dr. Naya McMillan, DrPH – Emergency Care Coordination Center (ECCC); Dr. Christa-Marie Singleton, MD, MPH – Centers for Disease Control (CDC)

A) Analysis of Medical and Public Health Trends in After-Action Reports/Improvements Plans: Dr. McMillian

- After-action reports (AAR) and improvement plans (IP) are the main product of the evaluation and improvement planning process.
- An AAR captures observations of an exercise and makes recommendations for post-exercise improvements.
- An IP identifies specific corrective actions, assigns them to responsible parties and establishes targets for their completion.
- This research had two main objectives:
    1. To establish proof-of-concept that existing AARs/IPs may be analyzed to recognize trends that may impact future preparedness exercises and or events.
    2. To identify areas of concern that highlights best practices, as well as other frequent observations in the submitted AARs/IPs.
- Seventy-two AARs/IPs (46 exercises/26 incidents) were selected and analyzed because they all met the following inclusion criteria:
    1. The AAR/IP had a significant focus on medical, public health, and emergency medical service (EMS) issues.
    2. The AAR/IP was drafted by a medical, public health or EMS organization.
    3. The AAR/IP's event received notable attention within the areas of medical, public health, or EMS.
- Specific information was collected for each AAR/IP and mission objectives were classified using TCL definitions. From those TCL definitions 17 broad categories were identified.
- The descriptive categories were assigned a numerical value in order to quantify the data and after review each AAR/IP was assigned to one of the following categories:
    1. Detailed and complete-1
    2. Somewhat detailed and complete-2
    3. Not detailed or complete-3
- Based on these three categories an improvement plan rating system was formulated. This five level scale was able to rate improvement plans of the individual AAR/IPs.
- Results and Key Findings:
    1. Study demonstrates the feasibility of analyzing trending in AARs/IPs.
    2. AAR quality ratings gradually improved after 2001.
    3. Overall quantity of AARs increased over time.
    4. Most collaboration occurred between local and state entities.
    5. There was an increase in quality ratings after HSEEP guidelines were introduced.
    6. Most common mission objectives were:
        i. test communications
        ii. test coordination
        iii. provide mass prophylaxis
    7. Corrective actions most frequently cited:
        i. planning
        ii. communications
        iii. responders' safety and health
    8. Within AARs/IPs, no clear consensus on basic elements to be represented in reports; key information was not clearly or consistently recorded in all AARs/IPS, which contributed to some of the limitations.
- Conclusions:

1. Advocate setting standards for AAR/IP data collection when the HSEEP guidelines are set to be updated in 2010.
2. Develop standardized mechanism for disseminating AARs/IPs and the lessons learned from this study and this could help establish trends in AARs/IPs.

B) Cost of State/Local Preparedness Exercises: Current Activities, Options for Future Data Collection: Dr. Christa-Marie Singleton

- In a time of shrinking dollars we have to ask "Is there bang for the buck?"
- At the CDC we designed a pilot project to organize an "Exercise Data Collection and Reporting Project."
- The purpose of the Exercise Data Collection and Reporting Project is to:
    1. Create an evidence base of components related to the exercise process that will help demonstrate performance.
    2. To determine how exercises (deemed as aids to validate plans and test operational proficiency) should be leveraged in a cost-effective manner when funding is limited.
    3. These two purposes let the CDC exercise the process to get at what it is specifically that its awardees need and want.
- In August 2008 we picked seven awardees to participate in a pilot and of those seven four responded via survey.
- Challenges with the survey:
    1. The data did not allow the CDC to compare apple-to-apples and oranges-to-oranges.
    2. The price of senior level participants was higher in certain exercises so costs were higher.
    3. Recommendations took 12-18 months to compile so this is a labor- intensive process.
    4. Many people viewed evaluation and planning to be one and the same, so it was hard to understand how they spent their money.
- Conclusions:
    1. Data shows that people are spending a lot of time planning but not a lot of time evaluating.
    2. Awardees' budget submissions varied in identification of contractual or other amounts dedicated to exercises.
    3. Respondents' ability to document number, duration and time spent by attendees presented at the full suite of planning meetings varied.
    4. Needed better tracking mechanisms.
    5. The sample size was small-we only tracked seven grantees.
- Recommendations for Future Data Elements:
    1. Collect costs for improvements instead of execution.
    2. Support (fund) and collect data on one smaller, agency based FSE/FE and one large multi-agency response FSE.
    3. Create a standardized methodology for exercise costs tracking.

D) Question and Answer Session: Open to all participants

1. Q: Is there any relationship between the amount of money spent and the effectiveness of preparedness? R (Singleton): That is the burning question. Do you really need to spend the big bucks on the full -scale multi -faceted exercises if you can spend less and get the same results? The federal government needs to come up with easier ways for people to document their outcomes and results as they are going through a process/exercise because if it is too time consuming people don't do it, and we lose that opportunity. Are larger or smaller exercises better? It depends on your objectives. Why do we do these larger exercises if there is no proof that they are more effective?
2. Q: As you expand your ability to determine what other costs are in healthcare, are you going to be looking at in-kind solutions? R (Singleton): Public health dollars only go so far, ideally we want people to collaborate for that exact reason.
3. Q: HHP and the PHP funds. Use of these funds is different depending on the side you are on and it can affect your ability to do a state -wide exercise. For example, Texas could not fund a state- wide exercise so most exercises they do are with various hospitals and

funded through staff dollars from HHP. It's hard to do cost sharing between the two programs and people do try to collaborate with other partners, but this is a challenge. We need to make it more consistent with the HHP and PHP so that we can do some cost cutting. R (Singleton): I agree with you. The ideal would be that everyone puts their money in and tells what their objectives are in the jurisdiction and works together.

4. (McMillan) Without standardization we cannot assess the information in the AARs, so perhaps a system such as CAPS would help. R (Singleton): The problem is that even when people plug in to the templates that are provided for use by a standardized system, things still get lost in translation, especially translating that standard action into practice.