



Hospital Preparedness Program (HPP) Cooperative Agreement

FY 12 Budget Period

Hospital Preparedness Program (HPP) Performance Measure Manual
Guidance for Using the New HPP Performance Measures

July 1, 2012 — June 30, 2013

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**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE**



**Hospital Preparedness Program (HPP)
Performance Measure Manual
Guidance for Using the
New HPP Performance Measures**

July 1, 2012 — June 30, 2013

The *Hospital Preparedness Program (HPP) Performance Measure Manual, Guidance for Using the New HPP Performance Measures (hereafter referred to as Performance Measure Manual)* is a highly iterative document. Subsequent versions will be subject to ongoing updates and changes as reflected in HPP policies and direction.

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Preface: How to Use This Manual

This manual is intended to be used to assist awardees of the Hospital Preparedness Program (HPP) in collecting performance measure results in the most reliable and valid manner possible. It should be used as a reference resource to clarify any ambiguities in the meaning of the performance measures or their component data elements. Rather than reading the manual cover-to-cover, it is expected that the manual will be used as a reference to “look up” specific items.

Any awardee receiving funds from the HPP should be aware of and understand that performance measures are required across the entire Federal government. Performance measures should tell the story of a program’s progress toward meeting its goals and achieving program outcomes. It is the responsibility of the program’s participants, in this case the entities receiving HPP funds, to provide performance information through performance measures as a means of contributing to the information the program needs to assess its effectiveness. The HPP performance measures are important because they allow the HPP to provide program performance information that will better enable the HPP to conduct future evaluations of program accomplishments.

This document includes all relevant information pertaining to the HPP performance measures and is publicly available. This manual will clearly provide:

- The rationale for the new HPP performance measures
- Full descriptions of the measures and data elements
- The method by which performance measure results will be calculated from data element responses
- Guidance on how to interpret key terms and phrases
- Recommendations for how best to collect data element responses

Note: The *Performance Measure Manual* is a highly iterative document. Subsequent versions will be subject to ongoing updates and changes as reflected in HPP policies and direction. While this document covers performance measures, it does not detail other measures/information that may be asked of awardees.

Document Organization

The chapters in this document consist of measures and evaluation tools for the eight (8) Healthcare Preparedness Capabilities found in HPP’s *Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness* (hereafter referred to as *Healthcare Preparedness Capabilities*). The chapters are organized alphabetically. Each capability chapter follows the structure below:

1. Introduction: Description of the capability, identification of the capability functions, and alignment of data elements to capability functions
2. Instructions: Detailed technical guidance information and instructions to operationalize the measures
3. Terms and Definitions: Key measurement terms and definitions

Sections within a measure are indicated by the following icons to help users quickly identify and find relevant information.

Figure 1: Measure Section Icons



The **compass** icon indicates the measure specification. Depending on the type of measure, this section will identify a numerator and denominator, a start and stop time, or criteria that need to be addressed.



The **gears** icon indicates data elements. This section contains all questions that must be answered and reported to ASPR.



The **bull's eye** icon indicates the intent of a measure.



The **puzzle pieces** icon indicates actions, outputs, or outcomes that should result from achievement of the performance measures. *



The **open book** icon indicates technical assistance guidance. This section identifies any other relevant information to help awardees collect and report measure data reliably and validly.



The **light bulb** icon indicates key questions that may help awardees respond to data elements for each performance measure. *



The **checklist** icon indicates reporting requirements. This section contains any additional reporting criteria that were not identified previously in the measure.



The **key** icon indicates data element terms. *

*Note: These ICONS are applicable to the HPP Performance Measure sections; many are also used in the HPP-PHEP Performance Measures.

Measures Structure: HPP-PHEP Performance Measures

At the beginning of each capability section containing an HPP-PHEP joint measure, a table is provided to demonstrate how and to which awardee group the reporting requirements for the measure and assessment tool apply.

Table 1: Example Reporting Requirements Table for HPP-PHEP Joint Measures

Measure Applies To:	Circumstances for Reporting:	Measure Type:	Measure Category:
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Reporting	<input checked="" type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Cities	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input checked="" type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input checked="" type="checkbox"/> Territories or Freely Associated States	<input checked="" type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding *	<input checked="" type="checkbox"/> Planned Event	<input checked="" type="checkbox"/> Data Collected By: HPP and/or PHEP

Definitions: HPP Performance Measures

Table 2 provides a short introduction to key terms that are threaded throughout the *HPP Performance Measure Manual*. The table is not a substitute for the larger definition set specific to each performance measure. It is however intended to set the stage for navigating the manual.

Table 2: Introductory Key Terms

Term	Definition
Performance Measure	An objective, quantifiable indicator used to demonstrate the implementation of activities, creation of outputs, or to quantify progress toward outcomes.
Data Element	A unit of data that can be directly and unambiguously reported.
Result	A data element or performance measure outcome submitted by a reporting entity. Data element results are combined to calculate a more nuanced performance measure result.
Target	The performance level goal for each performance measure
Capability	A skill, knowledge, and/or set of resources that makes a person or organization competent to achieve a specific outcome
Function	The critical elements that, in combination, define a complete capability

Data Element Responses: HPP Performance Measures

Table 3 below describes the scoring system (scoring code, response, and an associated definition) to be used with the HPP Performance Measures. A scoring code must be selected for each data element that requires a Yes or No Response. An HPP awardee is expected to implement each of the data elements within the HPP measures during the five-year HPP Cooperative Agreement period.

Table 3: Scoring System for the HPP Measures

Scoring Code	Response	Definition
"1"	YES	This element has been completely implemented consistent with national HPP expectations
"2"	NO	This element is partially implemented
"3"	NO	There IS a plan to start implementing this element within the next grant year*
"4"	NO	There is NO plan to implement this element within the next grant year.*
"5"	NO	There was no opportunity to implement this element within this grant year**

* If an awardee has reported having NO coalitions yet developed, it may only score a data element as a "3" or a "4" — All data elements must be answered by healthcare coalitions.

** This Scoring Code can be used ONLY for specified exercise related data elements in the absence of an exercise, incident, or event occurring during the reporting period.

The scoring system for HPP measures is intended to be mutually exclusive. The following bullets outlines possible scenarios based on responses to the exercise related questions. For example:

- If a coalition is intending NOT to exercise on a particular activity during the current grant year, but it is intending to do so during next grant year, and when this year's exercise is conducted the activity was NOT exercised, then the activity described in the data element (requiring an exercise or event) may be scored only as a "3", but NOT as a "5".

- If a coalition is intending NOT to exercise on a particular activity during this year, but it does not know when it will do so, and when this year's exercise is conducted the activity was NOT exercised, then the activity described in the data element (requiring an exercise or event) may be scored only as a "4", but NOT as a "5".
- If a coalition IS intending to exercise on a particular activity during the current grant year, but for some reason the exercise is NOT conducted this year, and there was no event that occurred in the absence of an exercise, then the activity described in the data element (requiring an exercise or event) may be scored only as a "5".
- If a coalition is intending NOT to exercise a particular activity during the current grant year, but for some reason the exercise is NOT conducted this year, and there was no event that occurred in the absence of an exercise, then the activity described in the data element (requiring an exercise or event) may be scored only as a "5".
- If a coalition is NOT SURE if it is intending to exercise a particular activity during the current grant year, but for some reason the exercise is NOT conducted this year, and there was no event that occurred in the absence of an exercise, then the activity described in the data element (requiring an exercise or event) may be scored only as a "5".

Measure Results: HPP Performance Measures

Performance measure information will be gathered at the data element level by each of the awardee's Healthcare Coalitions (HCCs). Generally, it will then be aggregated at the data element level by the awardee and transmitted to Assistant Secretary for Preparedness and Response (ASPR). ASPR will calculate the aggregation of the data elements resulting in the measure result for the awardee. In Budget Period 1 (BP 1), ASPR will pilot test various forms of performance measure reporting from coalitions and awardees to determine the greatest efficiencies possible with the least amount of burden. A coalition must submit a positive response for each of the data elements supporting a performance measure, for the performance measure to be met. A negative response by the HCC to any data element constitutes a negative reported answer to any performance measure. In the case where a coalition's response is dependent on some action on the part of one or more member healthcare organizations, any negative response to a data element by any member organization will result in an answer to be reported for the HCC for that data element.

Introduction

The HPP Performance Measures described in this manual are designed to track the healthcare community's progress toward achieving the capabilities detailed in the HPP ***Healthcare Preparedness Capabilities*** publication (<http://www.phe.gov/preparedness/planning/hpp/reports/documents/capabilities.pdf>). The ***Healthcare Preparedness Capabilities***, developed by the Assistant Secretary for Preparedness and Response (ASPR), identifies eight capabilities and 29 functions that address the span of the HPP's strategic focus. This document serves as a resource for diverse emergency planners to identify gaps in healthcare service delivery systems preparedness, systematically set priorities, and develop plans for building and sustaining healthcare specific capabilities. The ***Healthcare Preparedness Capabilities*** Guidance, in conjunction with the Capabilities document developed by the Centers for Disease Control (CDC) entitled ***Public Health Preparedness Capabilities: National Standards for State and Local Planning*** (http://www.cdc.gov/phpr/capabilities/dslr_capabilities/July.pdf), are intended to guide the development of ESF #8 preparedness planning activities to ultimately, assure safer, resilient, and better-prepared communities.

To advance all-hazards preparedness and national health security, promote responsible stewardship of Federal funds, and reduce awardee administrative burden, ASPR and CDC have engaged in a process of aligning the administrative and programmatic aspects of the ASPR's HPP and the CDC's Public Health Emergency Preparedness (PHEP) cooperative agreements.

The aligned HPP and PHEP cooperative agreement programs will follow the capabilities-based approach, building upon the strong preparedness foundation already in place at the State and local levels. Many PHEP and HPP programs already are closely aligned, and CDC and ASPR have similarly aligned to better support State and local efforts. The benefits of greater alignment of HPP and PHEP programs in the 62 awardee jurisdictions include:

- More coordinated and integrated public health and healthcare service delivery system planning and response
- Improved ability to leverage funding for applicable activities and infrastructure
- Reduced awardee burden regarding duplicative and sometimes conflicting activities and redundant reporting

HPP and PHEP grant alignment is a long-term initiative that will continue to evolve throughout the project period as the two programs seek additional opportunities to improve administrative and programmatic collaboration in the joint administration of the HPP and PHEP cooperative agreements. While working toward closer alignment in many aspects, ASPR and CDC recognize that the capabilities required to fulfill HPP and PHEP programmatic goals differ and that both programs will continue to remain stand-alone programs in accordance with their authorizing legislation. Funding is intended to help awardees demonstrate measurable and sustainable progress toward achieving the public health and healthcare preparedness capabilities outlined in this guidance and other activities that promote safer and more resilient communities. In the spirit of grant alignment, Fiscal Year 2012 (FY 12) performance measures include those that are specific to HPP, and also a new subset of performance measures jointly developed by ASPR and CDC, which will be used to satisfy the requirements of both programs.



The release of the ***Performance Measure Manual*** is designed to highlight the performance measures for healthcare service delivery systems and marks a shift in emphasis from building capabilities among individual facilities to strengthening capabilities through collaborations among diverse regional HCCs. This new perspective aims to broaden the scope of healthcare service delivery systems preparedness. To capture the progression toward the goals laid out in the guidance, the performance measures described within this manual are aspirational in nature, with the anticipation that achieving these capabilities on a national scale will require at least five years to accomplish.

Healthcare Coalitions

Healthcare Coalition Response Team (HCRT): The HCRT coordinates response activities between individual healthcare organizations (Tier 1) and between the HCC and jurisdictional authorities (Tier 3). A primary purpose for any HCC is to promote optimal situational awareness for its member organizations through the collection, aggregation, and dissemination of incident information. The HCRT can also facilitate resource support (mutual aid) between Coalition members, as well as assist with the acquisition and distribution of aid from other sources (e.g., jurisdictional authorities).

An ICS based organizational model is recommended for the HCRT because of its proven effectiveness in managing complex activities during incident response. However, despite this proposed model, it is important to emphasize that the HCRT serves principally as a coordinating entity in support of Coalition member organizations. It does not “command” the actions of Coalition members or any other response entities it might interact with during an emergency.¹

Evaluation and Healthcare Preparedness

Since 2002, ASPR has awarded funding through the HPP cooperative agreements to the 50 States, eight territories, and four metropolitan localities. The HPP cooperative agreement is intended to enable eligible entities to improve surge capacity and enhance community and hospital preparedness for public health emergencies. HPP funding helps awardees address gaps in healthcare preparedness, and refine and maintain medical surge capacity and capability at the State and local levels through associated planning, personnel, equipment, training, exercises, and HCC development.

Evaluating awardees performance provides critical information needed to report on how well this Federal investment in preparedness has improved the nation’s ability to prepare for and respond to health and medical emergencies. The Healthcare Systems Evaluation Branch (HSEB) within ASPR has been charged with developing and implementing a standardized set of relevant, feasible, and useful performance measures and other evaluation strategies as part of the HPP cooperative agreement, with a primary emphasis on program improvement and accountability.

¹ [Medical Surge Capacity and Capability: The Healthcare Coalition in Emergency Response and Recovery](http://www.remm.nlm.gov/MSCC_Healthcare_Coalition_May_2009.pdf) 2009. U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201. http://www.remm.nlm.gov/MSCC_Healthcare_Coalition_May_2009.pdf

Working in close collaboration with internal and external subject matter experts (SMEs), ASPR awardees, national partner organizations and Federal partners such as the CDC Division of State and Local Readiness (DSLRL) in CDC’s Office of Public Health Preparedness and Response (OPHPR), HSEB has developed a set of new performance measures for FY12 that enable ASPR and its HPP awardees to:

- Enhance **situational awareness** by assessing healthcare service delivery system capacity and operational capabilities throughout the nation.
- Provide **technical assistance** and other training to support awardee needs by identifying gaps and providing the appropriate support to mitigate challenges.
- Support **program improvement and inform policy** by translating analytical findings into information that decision-makers need to make course corrections, as needed. Through evidence based decision-making, levers for program improvement may be identified.
- Increase **transparency** by the dissemination of program progress and achievements through reports, publications, and presentations. The National Health Security Strategy (NHSS) emphasizes that “more attention should be given to systematic quality improvement methods to extract and disseminate ‘lessons learned’.”
- Promote **sound stewardship** of Federal tax dollars by using the data to assess impact of public funding and ensure that the American taxpayer sees a return on his or her investment. The development of program measures and continuous quality improvement enables HSEB to critically evaluate the ability of the HPP program to perform its intended goals.

Primer on Evaluation

This section is intended to provide readers with a basic understanding of evaluation concepts in order to lay the foundation for effective performance measurement.

What is evaluation?

Evaluation can be thought of — in simple terms — as collecting, analyzing and ultimately using data to make decisions.² *Program evaluation* entails collecting and analyzing data to make decisions about a program or aspects of a program. Ideally, data are collected and analyzed systematically to determine how well a program is working and why (or why not).³

There are many types of program evaluation, which can be conducted for a variety of purposes as shown in Table 4. Two of the more common types on which this guidance focuses include process evaluation and outcome evaluation. Process evaluations determine whether, and how well, program activities were implemented. Outcome evaluations, on the other hand, determine whether desired program results were achieved and the extent to which program activities contributed to these results.

² Patton, M.Q. (1982). *Practical Evaluation*. London: Sage Publications.

³ Government Accountability Office. (January 31, 2012). *Designing Evaluations 2012 Revision*. Accessible at <http://www.gao.gov/assets/590/588146.pdf>

Table 4: Types of Evaluation:

Program Integrity	Formative	<ul style="list-style-type: none"> ▪ Needs assessment ▪ Feasibility studies ▪ Process evaluation (including performance measurement) ▪ Implementation evaluation (including fidelity assessments) ▪ Output evaluations
Program Effectiveness	Summative	<ul style="list-style-type: none"> ▪ Outcome evaluation ▪ Comparative effectiveness studies ▪ Impact evaluation (overall net effects controlling for external influences)
Program Efficiency	Summative	<ul style="list-style-type: none"> ▪ Cost effectiveness studies ▪ Cost-benefit studies ▪ Output evaluation

Why do we conduct evaluations?

There are two primary reasons evaluations are conducted: to demonstrate accountability to stakeholders, including funders, and to facilitate internal program improvement (also referred to as organizational learning).

The U.S. Congress, Federal oversight agencies, State and local legislatures, and taxpayers alike expect to know the concrete results of HPP/ASPR investments and if the nation is better prepared to respond to health and medical emergencies. Should available HPP funds continue to decrease, the need to articulate HPP successes and impacts grows more urgent. Data gathered through program evaluation can enable State, local, and territorial HPP awardees to respond to requests for information from various stakeholders and provide evidence that HPP investments are being used as intended to achieve desired outcomes.

Equally as important as demonstrating accountability, is improving program performance. Program evaluation can help State, local, and territorial HPP awardees benchmark themselves in key areas, against which they can assess improvement over time. Evaluation that seeks to improve program performance tends to focus on the collection of data that organizations can use to learn about their strengths, weaknesses, and the critical chokepoints impeding optimal results.

To evaluate a program, it is helpful to understand the connections between program resources, activities, and goals. Logic modeling is one way to display these connections. Logic models identify and propose relationships between and among program resources, activities, outputs, and outcomes. Figure 2 provides a sample logic model, followed by definitions of its components.

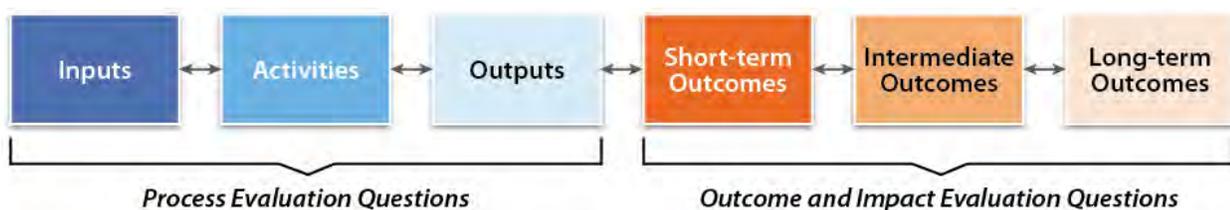
Figure 2: Sample Logic Model


Table 5: Definitions of Logic Model Components:

Component	Definition
Inputs	Resources that are required to support the program, including staff and volunteers, funding, facilities, and equipment.
Activities	Actions that use or involve program inputs.
Outputs	Products and services produced by program activities.
Outcomes	Changes or benefits resulting from program activities and outputs. Outcomes can be intended or unintended, positive or negative, and are often divided into short term, intermediate, and long-term timeframes.

What are the benefits of program evaluation?

There are numerous benefits to program evaluation, which include:

- Identifying program successes
- Identifying areas for improvement and increased efficiency
- Understanding the overall program or in part its contributions
- Increasing “buy-in” of staff, volunteers, collaborators, new partners, funders and the public
- Improving services provided through better management and monitoring⁴
- Disseminating program information

Performance Measurement as an Evaluation Strategy

How does measurement link to evaluation?

Measurement is one evaluation strategy, among many others. Measures may be developed for program inputs, activities, outputs, or outcomes, depending on the level of program development and implementation and programmatic areas of interest. Historically, HPP measures have focused on program activities and outputs, though as the program matures, so too does its measures.

How are measurement data used?

Just as with evaluation more broadly, measurement data can be used to facilitate internal program improvement and demonstrate accountability.

Improvement measures are designed to provide data to awardees and ASPR staff to enable identification of strengths, weaknesses, and areas of improvement, along with opportunities for training and technical assistance. The intended use of this measurement data is to facilitate internal program improvement and learning. *Most HPP measures have an improvement component.*

Accountability measures are collected in compliance with specific Federal requirements, statutes or initiatives such as the Pandemic and All-Hazards Preparedness Act (PAHPA), the Government Performance and Results Act (GPRA), and the Healthy People 2020 Initiative. Data from these measures are often reported to requesting agencies and other entities such as the US Department of Health and Human Services, the White House Office of Management and Budget (OMB), and others. Data from these accountability measures will be used to provide evidence to the aforementioned programs that the HPP

⁴ Mattesich, P.W. (2003). *The Manager’s Guide to Program Evaluation: Planning, Contracting, and Managing for Useful Results*. Saint Paul: Amherst H. Wilder Foundation.

awardees are conforming to funding requirements and demonstrating effectiveness in public health preparedness practice.

How were the FY 12 HPP performance measures developed?

ASPR began developing its HPP HCC measures as early as 2010 by engaging with its own HPP Metrics and Measurement Workgroup (MMWG)⁵ to obtain feedback about a possible rewrite of its hospital-based measures. During that time and since then, ASPR has engaged in the following measure development process:

1. Review literature and existing measures
2. Identify potential points of measurement with the MMWG, other SMEs and HPP program representatives
3. Socialize points of measurement with ASPR leadership to ensure they meet information needs of the HPP and overarching National Preparedness Program
4. Engage workgroups including members of the MMWG, other SMEs, awardees, and program representatives to draft measure specifications, intent, data elements, and reporting criteria
5. Conduct pilot tests and/or desk reviews of draft measures with stakeholders (e.g., State and local PHEP awardees) to determine relevance, feasibility, and usefulness and solicit suggestions for improvement
6. Develop final measures, implementation guidance, and tools
7. Develop performance measure training and facilitate technical assistance

Is performance measurement always the best evaluation method?

Although much focus has been placed on performance measurement to date, not all aspects of the HPP program or its capabilities are amenable to performance measurement. Some aspects may be better evaluated through methods such as surveys (e.g., ASPR's HPP Healthcare Coalition Questionnaire), observation, interviews, focus groups, document review, or other evaluation tools (e.g., the PARTNER tool⁶). ASPR will continue to incorporate these and other methods into its evaluation strategy whenever it is appropriate, and will collaborate with the HSEB-ASEB Evaluation Workgroup as part of its continued alignment activities.

What are the Reporting Requirements?

Starting in Budget period 1 (BP 1), *new* measures and evaluation tools have been developed for each of the eight capabilities described in *Healthcare Preparedness Capabilities*. These performance measures were announced in Appendices six (6) and seven (7) of the joint HPP-PHEP FY12 Funding Opportunity Announcement (FOA) and all awardees must report on these HPP-specific and HPP-PHEP joint performance measures along with their supporting data elements.

The 62 HPP awardees will be required to report performance measures and related evaluation and assessment data for these capabilities at least annually, as an end-of-year report. End-of-year reporting shall occur no later than September 30 following the close of the grant year. In addition, ASPR may ask awardees to report at mid-year under certain circumstances [e.g., in the presence of a new provisional measure(s)]. Mid-year reporting shall occur no later than January 31 following the start of the grant year.

⁵ The Metrics and Measurement Working Group (MMWG) is a cross-section HPP Awardees and other stakeholders that provide feedback to ASPR on how to best operationalize performance measures and evaluation activities.

⁶ <http://www.partnerool.net/>

Awardees are ultimately responsible to make arrangements with their HCCs for the collection of coalition level information to report to ASPR.

What types of measures are included in HPP’s performance measures?

The HPP BP 1 Performance Measures address aspects of both Healthcare Preparedness Planning and Healthcare Response.

- **Healthcare Preparedness Planning** — process measures that assess crucial preparedness activities such as: identifying and coordinating with partners, defining operational roles, defining triggers for action, and identifying barriers to public health participation in response and recovery.
- **Healthcare Response** — measures of performance while actually conducting, demonstrating or achieving a capability during an incident, planned event or exercise.
- **Healthcare Recovery** — measures of performance that describes the extent to which healthcare delivery services are restored within communities following an incident.

Table 6: Measure Types

Type of Measure	Reporting Criteria	Exceptions or Notes
Healthcare Preparedness Planning	Report annually, irrespective of the allocation of HPP funds towards the capability	In BP 1, ASPR will collect information from all awardees at Mid-Year and at the End-of Year. Measures reported for the Mid-Year during BP 1 will be used to refine and finalize the measures for BP 2 and beyond.
Healthcare Response	Report annually if an incident, exercise, or planned event utilizes the capability, irrespective of HPP funds allocated towards the capability	Exercise-related data elements within performance measures are specially marked. If no incident or event occurred during the reporting period, awardees shall report that “There was no opportunity to implement this element”
Healthcare Recovery	Report annually, irrespective of the allocation of HPP funds towards the capability	Encompasses both short-term and long-term efforts for the rebuilding and revitalization of affected communities.

The Operational Unit of Measurement

The operational unit for all HPP performance measures is at the healthcare coalition level. Therefore, the data elements included in the HPP performance measure set can only be answered by a respondent representing a healthcare coalition. Ultimately it is the HPP awardee that is responsible for making arrangements with its healthcare coalitions to provide answers to these data elements. The HCC’s data are sent to the awardee, and the awardee provides the data to ASPR. ASPR will then calculate the final result for each performance measure.

Sufficient Documentation

Awardees should maintain appropriate documentation for all data reported on the HPP-only and HPP-PHEP performance measures. Documentation should contain sufficient information to substantiate performance measure data submitted to ASPR. Documentation may be requested by ASPR to clarify or

verify information submitted by awardees. While a fully automated electronic system is an efficient means to maintain documentation of data for various performance measures, such a system is not necessary to meet measure requirements. Awardees may manually record all data elements.

List of Performance Measures

Table 7 below describes the performance measures that are specific to each of the eight capabilities described in *Healthcare Preparedness Capabilities*. The numbering convention for each measure corresponds to the healthcare preparedness capability. The HPP-PHEP joint performance measures were developed as part of the grant alignment process between CDC and ASPR and are included and addressed in this manual.

Table 7: Performance Measures

HPP Performance Measures		
HPP 1.1	Healthcare System Preparedness	Percent of healthcare coalitions (HCCs) that have established formalized agreements and demonstrate their ability to function and execute the capabilities for healthcare preparedness, response, and recovery as defined in Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness
HPP 2.1	Healthcare System Recovery	Percent of healthcare coalitions (HCCs) that have developed processes for short-term recovery of healthcare service delivery and continuity of business operations
HPP 3.1	Emergency Operations Coordination	Percent of healthcare coalitions (HCCs) that use an integrated Incident Command Structure (ICS) to coordinate operations and sharing of critical resources among HCC organizations (including emergency management and public health) during disasters
HPP 5.1	Fatality Management	Percent of healthcare coalitions (HCCs) that have systems and processes in place to manage mass fatalities consistent with their defined roles and responsibilities
HPP.6.1	Information Sharing	Percent of healthcare coalitions (HCCs) that can continuously monitor essential elements of information (EEl) and demonstrate the ability to electronically send data to and receive data from coalition members to inform a common operating picture
HPP 10.1	Medical Surge	Percent of healthcare coalitions (HCCs) that have a coordinated mechanism established that supports their members' ability both to deliver appropriate levels of care to all patients (including pre-existing patients [both inpatient and outpatient], non-disaster-related patients, and disaster-specific patients), as well as to provide no less than 20% bed availability of staffed members' beds, within 4 hours of a disaster
HPP 14.1	Responder Safety and Health	Percent of healthcare coalitions (HCCs) that have systems and processes in place to preserve healthcare system functions and to protect all of the coalition member employees (including healthcare and non-healthcare employees)
HPP 15.1	Volunteer Management	Percent of healthcare coalitions (HCCs) that have plans, processes and procedures in place to manage volunteers supporting a public health or medical incident
HPP-PHEP Joint Performance Measures		
HPP-PHEP 6.1	Information Sharing	Percent of local partners that submitted all requested Essential Elements of Information (EEI) to health and medical lead within the requested timeframe
HPP-PHEP 15.1	Volunteer Management	Proportion of volunteers deployed to support a public health or medical incident within the requested timeframe

Appendix C of this manual includes a crosswalk between the Resource Elements in the Healthcare Preparedness Capabilities that most closely associate with the HPP Performance Measures. Additionally, the Performance Measure section of the reporting template for the Online Data Collection system (OLDC) is included in Appendix D of this manual. Please note that the nomenclature and numbers for the Performance Measures in OLDC lead off with the number 3 (e.g. 3.1.1). The number three (3) merely represents Section “3” of the OLDC reporting tab. The numbers to follow the number “3” (e.g., 1.1) will then follow the numbering convention used throughout this manual.

**CAPABILITY-SPECIFIC
PERFORMANCE MEASURES**



HPP 1.1: Healthcare System Preparedness

Introduction

Healthcare system preparedness is the ability of a community's healthcare service delivery system to prepare, respond, and recover from incidents that have a public health and medical impact in the short and long term. The healthcare system role in community preparedness involves coordination with emergency management, public health, mental or behavioral health providers, community and faith-based partners, and State, local, and territorial governments in order to do the following:

- Provide and sustain a tiered, scalable, and flexible approach to attain needed disaster response and recovery capabilities while not jeopardizing services to individuals in the community
- Provide timely monitoring and management of resources
- Coordinate the allocation of emergency medical care resources
- Provide timely and relevant information on the status of the incident and healthcare system to key stakeholders

Healthcare system preparedness is achieved through a continuous cycle of planning, organizing, equipping, training, exercises, evaluations and corrective actions.

Capability Functions

- **Develop, refine, or sustain Healthcare Coalitions**
- **Coordinate healthcare planning to prepare the healthcare system for a disaster**
- **Identify and prioritize essential healthcare assets and services**
- **Determine gaps in the healthcare preparedness and identify resources for mitigation of these gaps**
- **Coordinate training to assist healthcare responders to develop the necessary skills in order to respond**
- **Improve healthcare response capabilities through coordinated exercise and evaluation**
- **Coordinate with planning for at-risk individuals and those with special medical needs**

HPP 1.1: Healthcare System Preparedness

Measure 1.1:

Percent of healthcare coalitions (HCCs) that have established formalized agreements and demonstrate their ability to function and execute the capabilities for healthcare preparedness, response, and recovery as defined in Healthcare Preparedness Capabilities.

Performance Target:

100% by the end of the project period (Year 1 data will be used to establish baselines).

Data Elements:

- Are there formal documents such as: Memoranda of Understanding (MOUs), Mutual Aid Agreements (MAAs), Interagency Agreement (IAAs), articles of incorporation, letters of agreement, contracts, charters, or other supporting formal documents?

- Has the HCC established a formal self-governance structure (e.g., By-laws for the board of directors and a charter that is multidisciplinary and representative of all members of the coalition)?
- Please estimate the total percentage of the State population covered by each HCC within the State
- Does the HCC include emergency management and public health as integral partners?
- Has the HCC and its members participated in at least one HSEEP-compliant exercise to test State, regional and facility-level healthcare disaster plans considering scenarios identified by a Hazard Vulnerability Assessment (HVA) within the past year?
- In the past year, did the HCC achieve its established exercise participation goals for its member organizations engagement in exercises or real events to test regional State, regional and facility-level healthcare disaster plan?
- In the past year, did the exercises or real events to test regional, State, and facility-level healthcare disaster plans demonstrate the HCC capabilities to function as a coordinated entity?
- Has the HCC successfully implemented "lessons learned" and corrective actions from an exercise or event within the past year?



Thinking It Through

Key Questions To Think Through Before Beginning to Answer the Data Elements

- Are there formal agreements that bind your HCC together?
- Is the HCC integrated with the command and control structure of the local, regional, or State jurisdiction?
- Does the HCC have a collaborative governance structure with defined roles and responsibilities for HCC leaders and member representatives?
- What is the population size of the HCC's geographical area and the relationship to the State population?
- Does the HCC coordinate/integrate with State, regional, tribal, county, and city (where applicable) emergency management and public health for emergency response and recovery planning?
- Has the HCC and its members participated with regional and State jurisdictions planning efforts to conduct a coordinated HVA within in the past 3 years?
- Has the HCC participated in regional or State exercises that evaluates one of the scenarios identified in the HVA?
- Have "lessons learned" and corrective actions been implemented?



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How is the measure calculated?

Numerator:

Number of HCCs that have established formalized agreements and demonstrate their ability to function and execute the capabilities for healthcare preparedness, response, and recovery as defined in the Healthcare Preparedness Capabilities.

Denominator:

Number of HCCs identified by awardees.

Result Calculation:

In order for an awardee to report a positive result for the performance measure, the HCC must answer ‘Yes’ to each data element. A negative response by the healthcare coalition to any data element will result in a negative answer ‘No’ for that performance measure.



Why is this measure important?

Collaborative HCCs can function as preparedness multipliers by providing leadership, organization, and sustainability for the purpose of regional healthcare preparedness and response activities. Coordination via a HCC can build upon and augment individual healthcare organization preparedness and promote the regional Emergency Support Function #8 activities such as Situational Awareness and Resource Coordination. This measure asks specific questions about sharing of resources and other aspects of coordinating preparedness, response and recovery activities that address coalition maturity. Because coordination between coalition members can involve delicate negotiations, the measure emphasizes that significant decisions affecting collaboration among coalition members should be discussed and finalized in some formal agreement as part of preparedness activities. A formal agreement avoids ambiguities that would otherwise burden

responders and slow down the overall healthcare response. The measure will be used to determine whether HCCs possess the capabilities defined in the Healthcare Preparedness Capabilities.



What other requirements are there for reporting measure data?

- Reporting for this measure is required for all awardees.
- Reporting for this measure is required at least annually, and at Mid-Year in BP 1.
- Awardees are expected to collect all data elements at the **HCC level**.



What data must be reported?

Data Element #1:

Are there formal documents such as: Memoranda of Understanding (MOUs), Mutual Aid Agreements (MAAs), Interagency Agreement (IAAs), articles of incorporation, letters of agreement, contracts, charters, or other supporting formal documents that define:

- The member organizations of the HCC?
- Formal agreement to aid coalition members and to share resources and information?
- A process to allow representation of subject matter experts (SMEs) to the HCC?
- Joint or cooperative activities with non-healthcare constituencies?
- Formal agreements to prepare to respond as part of the HCC? Formal agreements to prepare to respond as part of the HCC?



Technical Assistance Guidance:

The State and HCC member organizations encourage the development of essential partner memberships from the community’s healthcare organizations and response partners. These memberships are essential for ensuring the coordination of preparedness, response, and recovery activities. The composition of an HCC



must be based on the unique needs of the community. **There is no correct number of formal members, but an HCC membership must include at least one general hospital or acute care facility.**

A single document that is signed by multiple organizations can constitute a formal agreement as long as the individual signing the document on behalf of the member healthcare organization (HCO) has the authority to make binding decisions and to commit the resources that may be called for in HCC response plans.

The single HCC document (described above) may also make provision for sub-agreements or sub-contracts (e.g., with the county coroner), to perform required HPP functions that are much more limited in scope relative to the overall HCC's responsibilities under the HPP cooperative agreement.

Data Element #2:

Has the HCC established a formal self-governance structure (e.g., By-laws for the board of directors and a charter that is multidisciplinary and representative of all members of the coalition)?



Technical Assistance Guidance:

The HCC governance structure must be described in a document that is referenced or embedded in HCC membership agreements signed by HCC member organizations. The governance structure described must describe:

- Leadership roles within the HCC and the procedures for filling those roles
- Decision-making processes
- Process by which the governance structure may be modified
- How the HCC Leadership coordinates with ESF-8

Data Element #3:

Please estimate the total percentage of the State population covered by each HCC within the State.



Technical Assistance Guidance:

The 'population covered' should be calculated as:

- a) The Total Population of the State, City, or Territorial Awardee, divided by
- b) The 'population covered' by the geographic area within which the HCC provides healthcare services, as determined by the most recent census estimates in effect at the time that the HPP grant was awarded (i.e., the 2010 Census would be used for each year of the FY2012-2016 grant).

Data Element #4:

Does the HCC include emergency management and public health as integral partners?



Technical Assistance Guidance:

For a 'Yes' to be scored, at a minimum, there must be ACTIVE and ENGAGED regular HCC member representation (apart from the HCC decision making processes) by the primary decision making representative from each local Emergency Management Agency (EMA) and each local Public Health Department (LHD) that exists within the geographic or jurisdictional boundaries for the HCC.

- If representation does not occur on a regular basis, the HCC must have a written protocol that addresses how the HCC will interact with the primary decision making representative for each EMA and each LHD that exists within its jurisdictional boundaries.
- In the case of the EMA, representation can occur through a liaison to the primary decision making representative.



NOTE: Given the public health and healthcare nature of the HPP and PHEP grants, a liaison representative to the public health departments would not be sufficient to demonstrate public health being an integral partner to the HCC.

Data Element #5:

Has the HCC and its members participated in at least one HSEEP-compliant exercise to test State, regional and facility-level healthcare disaster plans considering scenarios identified by a Hazard Vulnerability Assessment (HVA) within the past year? (See Exercise Data Elements tab)



Technical Assistance Guidance:

Although the HPP FOA requires that all hospitals and HCCs participate in at least one regional or statewide exercise over the 5-year grant period, an HCC must identify each year whether the HCC and its members have participated in an exercise or an event. The HCC is strongly encouraged to participate in a yearly exercise or event if the opportunity arises. If there was no event or exercise, it must score 'No' = 5 because of no opportunity.

The HCC does not have to be the lead organizer, but the HCC must participate as an operational entity.

Data Element #6:

In the past year, did the HCC achieve its established exercise participation goals for its member organizations engagement in exercises or real events to test regional State, regional and facility-level healthcare disaster plan?



Technical Assistance Guidance:

For an HCC to score 'Yes' for this data element the following members must have been participants:

- 100% of the HCC's member hospitals,

- At least one long term care facility member
- At least one EMS agency
- At least one community health center or a Federally Qualified Health Center (if either is represented by membership on the HCC)
- At least one local public health dept.,
- At least a decision-making representative from each of the remaining HCC essential member partners.

If there was no event or exercise, it must score 'No' because of no opportunity.

Data Element #7:

In the past year, did the exercises or real events to test regional, State, and facility-level healthcare disaster plans demonstrate the HCC capabilities to function as a coordinated entity? (See Exercise Data Elements tab)



Technical Assistance Guidance:

ALL corrective actions resulting from the official After Action Report (AAR), and from any other type of "lessons learned" process organized by the HCC, must be identified regardless of whether the HCC has resources to correct them all. The HCC and its members are expected to prioritize ALL the corrective actions that are within their ability to correct, identify exactly what the HCC will do to correct them, and indicate the date by which the correction will be completed.

The HCC and its member HCOs (hereafter referred to in this document as the HCC and its HCOs) are expected to establish realistic, measurable, and time-specific resolutions to mitigate items identified as part of the corrective actions. **All corrective actions must be assigned a targeted completion date.**

To score a 'Yes' for this data element, the HCC must have fully completed the outstanding corrective actions from its formal AAR and any other "lessons learned" that were due to be completed during the reporting period, within



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the time frames and at the level of correction and completion, specified by the HCC.

If there was no event or exercise that occurred during the reporting period, then it must score 'No' because of no opportunity.

Data Element #8:

Has the HCC successfully implemented "lessons learned" and corrective actions from an exercise or event within the past year? (See Exercise Data Elements tab)



Technical Assistance Guidance:

The phrase "successfully" implemented as used in Data Element #8 refers to meeting the objectives specified in the exercise.

ALL corrective actions resulting from the official AAR, and from any other type of "lessons learned" process organized by the HCC, must be identified regardless of whether the HCC has resources to correct them all. The HCC and its members are expected to prioritize ALL the corrective actions that are within their ability to correct, identify exactly what the HCC will do to correct them, and indicate the date by which the correction will be completed.

The HCC and its member HCOs are expected to establish realistic, measurable, and time-specific resolutions to mitigate items identified as part of the corrective actions. **All corrective actions must be assigned a targeted completion date.**

To score a 'Yes' for this data element, the HCC must have fully completed the outstanding corrective actions from its formal AAR and any other "lessons learned" that were due to be completed during the reporting period, within the time frames and at the level of correction and completion, specified by the HCC.

If there was no event or exercise that occurred during the reporting period, then it must score 'No' because of no opportunity.



Putting the pieces together

- Describe formal aid agreements that exists amongst the HCC and its members
- Identify the set of rules under which the HCC operates
- Describe the level of HCC integration with local, regional, and State jurisdiction planning for emergency response through exercise participation in line with threats identified in the jurisdictional HVA
- Describe the capability of the HCC to function as a coordinated entity in a response exercise or event
- Identify HCC corrective actions and implementation strategies





Key Definitions

Healthcare Constituencies: The people involved in or served by the HCC.

Memoranda of Understanding (MOUs) or Memoranda of Agreement (MOAs): Documents that describe a bilateral or multilateral agreement between two or more parties. These documents express an intended common line of action, establish a scope of association, and define mutual responsibilities. They are often used in cases where parties do not wish to or cannot create a legally enforceable agreement.

Charter: A written instrument that creates or defines an organization and describes the organization's functions.

Hazard Vulnerability Assessment (HVA): A systematic approach to recognizing hazards that may affect demand for services or the ability to provide those services. The risks associated with each hazard are analyzed to prioritize planning, mitigation, response, and recovery activities. An HVA serves as a needs assessment and a strategy to identify those hazards that are most likely to have an impact on a facility and the surrounding community. The HVA process should involve community partners and be communicated to community emergency response agencies (DHHS, 2009).

After-Action Report (AAR): A retrospective analysis of an event or exercise that is used to assess performance and assist in improving future performance.

Healthcare Coalition (HCC): The HCC is a collaborative network of healthcare organizations and their respective public and private sector response partners that serve as a multiagency coordinating group to assist with preparedness, response, recovery, and mitigation activities related to healthcare organization disaster operations. The primary function of the HCC includes sub-state regional, healthcare system emergency preparedness activities involving the member organizations. This includes planning, organizing and equipping, training, exercises and evaluation. During response, HCCs should represent healthcare organizations by providing multi-agency coordination in order to provide advice on decisions made by incident management regarding information and resource coordination for healthcare organizations. This includes either a response role as part of a multi-agency coordination group to assist incident management (area command or unified command) with decisions, or through coordinated plans to guide decisions regarding healthcare organization support.



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HPP 2.1: Healthcare System Recovery

Introduction

Recovery encompasses both short-term and long-term efforts for the rebuilding and revitalization of affected communities. Recovery planning builds stakeholder partnerships that lead to community restoration and future sustainability and resiliency. Recovery planning must provide for a near-seamless transition from response activities to short-term recovery operations. Planners should design long-term recovery plans to maximize results through the efficient use of resources and incorporate national recovery doctrine as outlined in the National Disaster Recovery Framework (NDRF).⁶

Successful healthcare service delivery system recovery is contingent on the resilience that is built through early and regular collaboration done with community partners. Working with partners such as public health, business, education, and emergency management can help to plan and advocate for the rebuilding of public health, medical, and mental or behavioral health systems to at least a level of functioning comparable to pre-incident levels and improved levels where possible. The focus is on an effective and efficient return to normalcy or a new standard of normalcy for the provision of healthcare delivery to the community. Recovery must be planned for as part of the preparedness process to facilitate an effective and efficient return to normal healthcare delivery operations, when needed.

Capability Functions

- **Develop recovery processes for the healthcare delivery system**
- **Assist healthcare organizations to implement Continuity of Operations (COOP)**

HPP 2.1: Healthcare System Recovery

Measure 2.1:

Percent of healthcare coalitions (HCCs) that have developed processes for short-term recovery of healthcare service delivery and continuity of business operations.

Performance Target:

100% by the end of the project period (Year 1 data will be used to establish baselines).

Data Elements:

- Has a risk-based regional/jurisdictional Hazard Vulnerability Analysis (HVA) been conducted within the past 3 years that identifies events and incidents that may impact the ability of HCC member hospitals and other HCOs to deliver healthcare?
- Have those identified events or incidents from the HVA been assessed as to their potential impacts on the hospital and other HCC members, such as power outages, water outages, road outages and supply chain disruptions?
- Have healthcare recovery needs been identified and prioritized based on those potential impacts resulting from the HVA?
- Does the HCC ensure that its hospitals and other HCOs are integrated in the jurisdiction's Emergency Operations Plan that is intended to meet prioritized essential healthcare recovery needs?

⁶ This reference can be found at www.fema.gov/recoveryframework/

- Has the HCC, its hospitals, and other HCO members implemented AND tested plans and processes for continuing and sustaining operations (e.g., hardening facilities), within the past three years?
- Does the HCC coordinate with each of its member hospitals and other HCOs to enhance member support in planning for continuity of operations plans?
- Has the HCC coordinated with the State and with its HCOs to develop a regional recovery and continuity of operations plan?
- Does the HCC coordinate its hospitals' and other HCOs' use of Electronic Medical Records, and link their use in their continuity of operations plans?
- Do HCC hospitals and other HCOs incorporate guidance on messaging to their workforce into their continuity of operations plans?
- Can HCC hospitals and other HCOs maintain essential functions (e.g. continue to bill for payment with healthcare insurers) to sustain revenues to operate during and after an emergency?
- Has the HCC successfully tested processes for short-term recovery of healthcare service delivery and continuity of business operations in an exercise or event? Has this taken place within the past year?
- Has the HCC successfully implemented lessons learned and corrective actions from this exercise or event?



Thinking It Through

Key Questions

- Has a jurisdictional or regional risk-based HVA been conducted that identifies and prioritizes a set of threats?
- Has the HCC and its members assessed threats identified in the HVA as to their potential infrastructure impacts on critical services, systems, security, safety, key resources and supplies.
- Has HCC recovery priorities been identified and communicated to State and local agencies?
- What are the recovery processes to mitigate potential infrastructure disruptions?
- When and how do you use backup generators, secondary communication capabilities, etc.?
- Do HCC member HCOs' COOP plans include sustainment of essential functions, critical applications, processes, personnel, workforce messaging, and functions?
- Has the HCC and its members coordinated/integrated with the regional, State, or local recovery plan?
- Does the HCC coordinate with its members to regarding planning, accessing, and communicating Electronic Medical Records amongst the HCC, local, regional, and State jurisdictions?
- Have HCOs made revenue sustainment arrangements with insurers, government agencies, and others as part of the business continuity planning?
- Has the HCC participated in an incident, planned event or exercise that demonstrated its ability to continue business operations during infrastructure outages?
- Have corrective actions been systematically recorded and implemented as part of an improvement plan?



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How is the measure calculated?

Numerator:

Number of HCCs that have developed processes for short-term recovery of healthcare service delivery and continuity of business operations

Denominator:

Number of HCCs identified by awardees

Result Calculation:

In order for an awardee to report a positive result for the performance measure, the HCC must answer ‘Yes’ to each data element. A negative response by the HCC to any data element will result in a negative answer ‘No’ for that performance measure



Why is this measure important?

Successful healthcare service delivery system recovery is contingent on the resilience that is built through collaboration with community partners, (e.g., public health, business, education, and emergency management) to plan and advocate for the rebuilding of public health, medical, and mental or behavioral health systems to at least a level of functioning comparable to pre-incident levels and improved levels where possible. The focus is on an effective and efficient return to normalcy or a new standard of normalcy for the provision of healthcare delivery to the community. Recovery must be planned for as part of the preparedness process to facilitate an effective and efficient return to normal healthcare delivery operations. This measure determines whether HCCs and their membership have processes in place that will enable a smooth and rapid recovery after a disaster.



What other requirements are there for reporting measure data?

- Reporting for this measure is required for all awardees.
- Reporting for this measure is required at least annually, and at Mid-Year in BP 1.
- Awardees should collect all data elements at the **HCC level**.



What data must be reported?

Data Element #1:

Has a risk-based regional or jurisdictional HVA been conducted within the past 3 years that identifies events and incidents that may impact the ability of HCC member hospitals and other HCOs to deliver healthcare?



Technical Assistance Guidance:

If the HVA is out of date, then any planning, exercises, etc. that have been completed since the date that the HVA expired cannot count toward scoring ‘Yes’ on any data element within these 8 HPP performance measures.

The “3 year” interval for a new HVA to occur is anytime within the 37th month or earlier from the date of the last HVA.

Data Element #2:

Have those identified events or incidents from the HVA been assessed as to their potential impacts on the hospital and other HCC members, such as power outages, water outages, road outages and supply chain disruptions?



Technical Assistance Guidance:

To score a ‘Yes’ for this data element, it is expected that every Hospital and every other essential partner in the HCC will be assessed for



potential impact resulting from the jurisdictional HVA.

NOTE: “Essential partners” include all of the HCC’s essential member partners (as defined in Capability 1: P3 of the healthcare preparedness capability framework document).

Data Element #3:

Have healthcare recovery needs been identified and prioritized based on those potential impacts resulting from the HVA?



Technical Assistance Guidance:

There may be insufficient resources to address all the member’s short-term recovery needs, so the HCC as a group must decide the cutoff for working on its collective priorities.

To score a ‘Yes’ for this data element:

- Each HCO is expected to initially identify and prioritize recovery needs specific to its own organization.
- In coordination with the State and essential partner memberships, the HCC is expected to identify, roll-up and prioritize regional or systemic healthcare recovery needs based on its members’ priority needs.

Data Element #4:

Does the HCC ensure that its hospitals and other HCOs are integrated in the jurisdiction’s Emergency Operations Plan that is intended to meet prioritized essential healthcare recovery needs?



Technical Assistance Guidance:

The HCC ensures that its member HCOs develop, employ, and evaluate processes to identify recovery processes within Emergency Operations Plans in order to assist if available and requested to meet healthcare recovery needs.

Data Element #5:

Has the HCC, its hospitals, and other HCO members implemented AND tested plans and processes for continuing and sustaining operations (e.g., hardening facilities), within the past three years?



Technical Assistance Guidance:

In order to answer ‘Yes’ indicating a positive result for this data element, the HCC and its HCOs must have:

- Implemented plans and process that address maintenance of essential services and supplies, and primary access to utilities (e.g. power and water).
- The plans must be consistent with the HCC’s list of prioritized needs.
- These plans and processes must be implemented in the time frames and at the level of completion specified in the HCC’s plans.
- The plans and processes must be tested within the past 3 years.

Data Element #6:

Does the HCC coordinate with each of its member hospitals and other HCOs to enhance member support in planning for continuity of operations plans?



Technical Assistance Guidance:

In order to answer “Yes’ indicating a positive result for this data element, 100% of HCC members are expected to have plans and systems in place that include at least:

- 1) Plans to mitigate against:
 - Power outage
 - Water outage
 - Telephone, cell phone, or internet outage;
- 2) Procedures for the following during response and recovery:



- Interfacing with the public
 - Integrating volunteers
- 3) Identification of essential services and associated staff or supply needs.
- 4) The HCC provides resources to its HCOs related to continuity of business (if assistance is requested), consistent with the HCC’s priority list of recovery services to which it can provide enhanced support.

Data Element #7:

Has the HCC coordinated with the State and with its HCOs to develop a regional recovery and continuity of operations plan?



Technical Assistance Guidance:

In order to an answer ‘Yes’ indicating a positive result for this data element:

- A regional COOP plan must exist.
- The HCC and all of its members must be aware of the regional COOP plan.
- Organizations that have assigned roles and responsibilities in the regional plan must have planned to execute the actions described in the plan when triggered by conditions specified in the regional COOP plan.

Data Element #8:

Does the HCC coordinate its hospitals’ and other HCOs’ use of Electronic Medical Records, and link their use in their continuity of operations plans?



Technical Assistance Guidance:

The regional COOP plan is required to incorporate the use of electronic medical records in order for the HCC to answer ‘YES’.
(It’s not necessary to check the plans of each HCO individually). The HCC must have the ability

to interface with each other’s systems in order to exchange health data when needed.

All of the hospitals and HCOs must have systems in place to provide necessary patient healthcare information in an emergency, if authorized and available.

Data Element #9:

Do HCC hospitals and other HCOs incorporate guidance on messaging to their workforce into their continuity of operations plans?



Technical Assistance Guidance:

In order to answer ‘Yes’ indicating a positive result for this data element, 100% of the HCC’s hospitals and other HCO’s and healthcare provider types that are deemed to deliver essential healthcare services, must meet this requirement in accordance with the priority needs identified by the HCC membership.

Data Element #10:

Can HCC hospitals and other HCOs maintain essential functions (e.g. continue to bill for payment with healthcare insurers) to sustain revenues to operate during and after an emergency?



Technical Assistance Guidance:

In order to answer ‘Yes’ indicating a positive result for this data element, the HCC’s hospitals and its other HCOs and healthcare providers who deliver essential healthcare services and bill for these healthcare services, must have met this requirement.



Data Element #11:

Has the HCC successfully tested processes for short-term recovery of healthcare service delivery and continuity of business operations in an exercise or event? Within the past year?


Technical Assistance Guidance:

The phrase “successfully” tested as used in Data Element #11 refers to meeting the objectives specified in the exercise.

Although the HPP FOA requires that all hospitals and HCCs participate in at least one regional or statewide exercise over the 5-year grant period, an HCC must identify each year whether the HCC and its members have participated in an exercise or an event. The HCC is strongly encouraged to participate in a yearly exercise or event if the opportunity arises. If there was no event or exercise, it must score ‘No’ because of no opportunity.

The HCC does not have to be the lead organizer, but the HCC must participate as an operational entity.

Data Element #12:

Has the HCC successfully implemented “lessons learned” and corrective actions from this exercise or event?


Technical Assistance Guidance:

The phrase “successfully” implemented as used in Data Element #12 refers to meeting the objectives specified in the exercise.

It is the expectation that the HCC will be participating in regional exercises. As such, the HCC is responsible for successfully coordinating and identifying all issues and is expected to address all identified issues for which the HCC and its HCOs have control.

The HCC and its HCOs are expected to establish realistic, measureable, and time-specific resolutions to mitigate items identified as part

of the corrective actions. All corrective actions must be assigned a targeted completion date.

To score a ‘Yes’ for this data element, the HCC must have fully completed the outstanding corrective actions from its formal AAR and any other “lessons learned” that were due to be completed during the reporting period, within the time frames and at the level of correction and completion, specified by the HCC. If there was no event or exercise, it must score ‘No’ because of no opportunity.


Putting the pieces together

- Identify threats that may impact the ability of the HCC and member hospitals and other healthcare organizations to deliver healthcare.
- Describe potential impact on the HCC and member hospitals and healthcare organizations.
- Describe the level of integration in the jurisdictions Emergency Operation Plan.
- Evaluate process and plans for continuing and sustaining operations through tests and exercises.
- Describe the level of integration in the jurisdictions recovery and continuity of operations plan.
- Evaluate the ability of the HCC hospitals and other HCOs to maintain essential functions to continue to bill for payment to sustain revenues to operate during an emergency through tests and exercises.
- Identify and implement needed corrective actions resulting from tests and exercises that evaluate the HCC hospitals and other HCOs to maintain essential functions to continue to bill for payment to sustain revenues to operate during an emergency.
- Describe the effectiveness of short-term recovery of healthcare services delivery and continuity of business operations plans for HCC, HCC hospitals, and other HCOs through tests and exercises.



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- Identify and implement needed corrective actions resulting from tests and exercises that evaluate the effectiveness of short-term recovery of healthcare services delivery and continuity of business operations plans for HCC, HCC hospitals, and other HCOs.



Key Definitions

Hazard Vulnerability Assessment (HVA): A systematic approach to recognizing hazards that may affect demand for services or the ability to provide those services. The risks associated with each hazard are analyzed to prioritize planning, mitigation, response, and recovery activities. An HVA serves as a needs assessment and a strategy to identify those hazards that are most likely to have an impact on a facility and the surrounding community. The HVA process should involve community partners and be communicated to community emergency response agencies.

Supply Chain: A system of organizations, people, technology, activities, information, and resources involved in moving a product or service from supplier to customer.

Emergency Operations Plan (EOP): An ongoing plan for responding to a wide variety of potential hazards.

Recovery Processes: The development, coordination, and execution of service- and site-restoration plans; the reconstitution of government operations and services; individual, private-sector, nongovernmental, and public assistance programs to provide housing and to promote restoration; long-term care and treatment of affected persons; additional measures for social, political, environmental, and economic restoration; evaluation of the incident to identify “lessons learned”; post incident reporting; and development of initiatives to mitigate the effects of future incidents .

Continuity of Operations (COOP): An effort to ensure that primary mission-essential functions (PMEFs) continue to be performed during a wide range of emergencies, including localized acts of nature, accidents, and technological or attack-related emergencies. A continuity of operations plan is a document that identifies the PMEFs and describes the tasks, processes, and systems requirements to maintain PMEFs.

Business continuity: The ability of an organization to provide service and support for its customers and to maintain its viability before, during, and after a business continuity event.



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HPP 3.1: Emergency Operations Coordination

Introduction

Emergency operations coordination regarding healthcare is the ability for healthcare organizations to engage with incident management at the Emergency Operations Center or with on-scene incident management during an incident to coordinate information and resource allocation for affected healthcare organizations. This is done through multi-agency coordination representing healthcare organizations or by integrating this coordination into plans and protocols that guide incident management to make the appropriate decisions. Coordination ensures that the healthcare organizations, incident management, and the public have relevant and timely information about the status and needs of the healthcare service delivery system in the community. This enables healthcare organizations to coordinate their response with that of the community's response and according to the framework of the National Incident Management System (NIMS).

Capability Functions

- **Healthcare organization multi-agency representation and coordination with emergency operations**
- **Assess and notify stakeholders of healthcare delivery status**
- **Support healthcare response efforts through coordination of resources**
- **Demobilize and evaluate healthcare operations**

HPP 3.1: Emergency Operations Coordination

Measure 3.1:

Percent of HCCs that use an integrated Incident Command Structure (ICS) to coordinate operations and sharing of critical resources among HCC organizations (including emergency management and public health) during disasters

Performance Target:

100% by the end of the project period (Year 1 data will be used to establish baselines)

Data Elements:

- Have the HCC and its members successfully exercised protocols for notifying non-partner support agencies to activate mutual aid agreements for resource support within the last year?
- Has the HCC planned with partner hospitals and other HCOs to identify each hospital and other HCO's maximum patient capacity to establish its baseline as a coalition?
- Has the HCC coordinated healthcare response operations with appropriate patient transport operations within the community, in an exercise or event, within the past year?
- In the past year, which of the following functions were successfully demonstrated by the HCC's hospitals and other HCOs in the exercise or event in which the HCC participated? Triage, Treatment, Transport, Tracking of patients, Documentation of care, and Off-loading?
- Has the HCC successfully exercised notification protocols for its hospitals and other HCOs within the last year?

- Are HCC members integrated into an HCC incident command structure such that the members are included in HCC Regional Plans?



Thinking It Through

Key Questions

- Does the HCC and its members have protocols or mutual aid agreements in place for engagement and coordination with non-partner support agencies during a response?
- Can the HCC quantify maximum patient bed capacity for each of its members?
- Is the HCC integrated with patient transport operations within the community?
- Is the HCC able to successfully demonstrate triage, treatment, transport, tracking of patients, documentation of care, or off-loading as part of an exercise or event?
- Is the HCC integrated into a broader jurisdictional response and incident command?



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How is the measure calculated?

Numerator:

Number of HCCs that use an integrated ICS to coordinate operations and sharing of critical resources among coalition organizations (including emergency management and public health) during in disasters.

Denominator:

Number of HCCs identified by awardees.

Result Calculation:

In order for an awardee to report a positive result for the performance measure, the HCC must answer 'Yes' to each data element. A negative response by the HCC to any data element will cause a negative result to be reported for the coalition for that performance measure.



Why is this measure important?

To determine whether HCCs are organized around an integrated Incident Command Structure.



What other requirements are there for reporting measure data?

- Reporting for this measure is required for all awardees.
- Reporting for this measure is required at least annually, and at Mid-Year for BP 1.
- Awardees are expected to collect all data elements at the **HCC level**.



What data must be reported?

Data Element #1:

Has the HCC and its members successfully exercised protocols for notifying non-partner support agencies to activate mutual aid agreements for resource support within the last year?



Technical Assistance Guidance:

The purpose of the activity is to exercise a redundant local level support network to ensure that the HCC members can get the resources they need.

A non-partner support agency is an organization that does not have a formal agreement to be a full member of the HCC but which has agreed to lend aid during a response (e.g. private business).

The mutual aid or local level agreement may or may not have been formalized in a written agreement in order to be included in this metric, as long as it is successfully activated.

The protocols are considered to have been 'successfully exercised' if all agreements that are reasonable in the context of the event are successfully activated.

Although the HPP FOA requires that all hospitals and HCCs participate in at least one regional or statewide exercise over the 5-year grant period, an HCC must identify each year whether the HCC and its members have participated in an exercise or an event. The HCC is strongly encouraged to participate in a yearly exercise or event if the opportunity arises. If there was no event or exercise, it must score 'No' because of no opportunity.

The HCC does not have to be the lead organizer, but the HCC must participate as an operational entity.



Data Element #2:

Has the HCC planned with partner hospitals and other HCOs to identify each hospital and other HCO’s maximum patient capacity to establish its baseline as a coalition?



Technical Assistance Guidance:

It is expected that the HCC and its members together establish a baseline of the HCC’s total bed capacity for the defined geographic region to achieve the goal outlined in Capability 10.1, Function 3.

Once there is an established HCC baseline, then the necessary calculations related to surge can be established:

- Diversion of patients to maintain baseline.
- Capability or Capacity Building necessary to reach 20% beds above baseline.
- Decompression to achieve 20% of baseline “immediate” bed availability (i.e., within four-hours of a disaster).
- If crisis standards of care have been defined, capacity can be calculated, assuming alternate care standards are in effect.

The “maximum patient capacity” is the staffed bed capacity of the hospital or other ‘inpatient’ HCO providers during peak operation as calculated for an accrediting organization. The baseline does not include any “extra” peak capacity (See Capability 10, F 3 page 36), such as Alternate Care Sites, that its HCOs could plan to “stand up” and staff.

Data Element #3:

Has the HCC coordinated healthcare response operations with appropriate patient transport operations within the community, in an exercise or event, within the past year?



Technical Assistance Guidance:

The exercise or event must have included patient transport processes (as defined in Capability X, Function 3) capable of transporting victims from every location affected by the event or exercise.

Although the HPP FOA requires that all hospitals and HCCs participate in at least one regional or statewide exercise over the 5-year grant period, an HCC must identify each year whether the HCC and its members have participated in an exercise or an event. The HCC is strongly encouraged to participate in a yearly exercise or event if the opportunity arises. If there was no event or exercise, it must score ‘No’ because of no opportunity.

The HCC does not have to be the lead organizer, but the HCC must participate as an operational entity.

Data Element #4:

In the past year, which of the following functions were successfully demonstrated by the HCC’s hospitals and other HCOs in the exercise or event in which the HCC participated?

- Triage
- Treatment
- Transport
- Tracking of patients
- Documentation of care
- Off-loading



Technical Assistance Guidance:

The event or the nature of the exercise is the driver as to which of the 6 (or all of the 6) functions must be successfully demonstrated.

In order to respond that a function was ‘successfully demonstrated,’ the function must have been included in the scope of the exercise and must have achieved exercise goals specific to each capability.



This data element relates specifically to exercise of patient transport processes.

To score 'Yes' to this data element, all of the disaster protocols necessary to be in place for triage, treatment, transport, patient tracking, etc., between participating agencies who were sending and receiving patients, and the transport agency, as appropriate for the actual transportation event and setting must have been demonstrated for an HCO to be counted as having met the EOC exercise requirement.

If there was no event or exercise, it must score 'No' because of no opportunity.

Data Element #5:

Has the HCC successfully exercised notification protocols for its hospitals and other HCOs within the last year?



Technical Assistance Guidance:

The phrase “successfully” exercised as used in Data Element #5 refers to meeting the objectives specified in the exercise.

The HCC plan must clearly identify who will do the notification and the process for notification.

Implementation of the HCC plan must demonstrate the ability to notify all members of trigger conditions and to confirm that members are activating roles and responsibilities to which they have committed.

As ongoing communication is included in the 'IS' data elements, the scope of this particular data element is the notification of HCC member organizations that must activate.

Although the HPP FOA requires that all hospitals and HCCs participate in at least one regional or statewide exercise over the 5-year grant period, an HCC must identify each year whether the HCC and its members have participated in an exercise or an event. The HCC is strongly encouraged to participate in a yearly exercise or event if the opportunity arises. If there was no event or exercise, it must score 'No' because of

no opportunity. The HCC does not have to be the lead organizer, but the HCC must participate as an operational entity.

Data Element #6:

Are HCC members integrated into an HCC incident command structure such that the members are included in HCC Regional Plans?



Technical Assistance Guidance:

The HCC is responsible for coordinating and ensuring integration of its members into the jurisdictional incident command structure.



Putting the pieces together

- Determine what formal agreements are in place to offer resource support
- Determine the maximum patient capacity of all coalition member HCOs
- Describe the baseline bed capacity for the HCC
- Evaluate the level of HCC integration with the appropriate patient transport operations within the community through tests and exercise participation
- Identify and implement needed corrective actions resulting from tests and exercises that evaluate the HCC integration with the appropriate patient transport operations within the community.



Pre-Incident

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HPP 5.1: Fatality Management

Introduction

Fatality management is the ability to coordinate with organizations (e.g., law enforcement, healthcare, emergency management, and medical examiner or coroner) to ensure the proper recovery, handling, identification, transportation, tracking, storage, and disposal of human remains and personal effects; certify cause of death; and facilitate access to mental or behavioral health services for family members, responders, and survivors of an incident. Coordination also includes the proper and culturally sensitive storage of human remains during **death surges**.

Capability Functions

- **Coordinate surges of deaths and human remains at healthcare organizations with community fatality management operations**
- **Coordinate surges of concerned citizens with community agencies responsible for family assistance**
- **Mental or behavioral support at the healthcare organization level**

HPP 5.1: Fatality Management

Measure 5.1:

Percent of healthcare coalitions (HCCs) that have systems and processes in place to manage mass fatalities consistent with their defined roles and responsibilities.

Performance Target:

100% by the end of the project period (Year 1 data will be used to establish baselines)

Data Elements:

- Has the HCC identified the roles and responsibilities of member organizations and other key partners for managing mass fatalities?
- Has the HCC established systems and processes to manage mass fatalities consistent with its defined roles and responsibilities?
- Has the HCC established systems and processes to manage a surge of concerned citizens requesting information about missing family members, including how to contact the responsible agency for family support, and protocols to ensure its HCOs can connect with family assistance and/or family reception centers?
- Has the HCC successfully tested its systems and processes for managing mass fatalities during an exercise or event? Has this taken place within the past year?
- Has the HCC successfully implemented lessons learned and corrective action from this exercise or event within the past year?



Thinking It Through

Key Questions

- Which agency/department has the lead role in FM for your jurisdiction?
- How are decedents processed in your jurisdiction normally/during a disaster?
- What are the roles and responsibilities of locals, regional and State government agencies?
- Who is responsible for processing death certificates, decedent recovery and identification, notify next of kin, etc.
- Has the HCC coordinated with local, regional, or State jurisdictions in order to identify the roles and responsibilities for its member hospitals, and other HCOs for Fatality Management?
- Do the individual facility plans align with the lead agency's plan?
- Who is responsible for Family Assistance Centers (FACs) in the locals, regional and State government agencies?



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How is the measure calculated?

Numerator:

Number of HCCs (including health departments, participating hospitals, emergency management, coroners and medical examiners, funeral directors and other awardee-defined response entities) that have systems and processes in place to manage mass fatalities consistent with their defined roles and responsibilities.

Denominator:

Number of HCCs identified by awardees.

Result Calculation:

In order for an awardee to report a positive result for the performance measure, the HCC must answer 'Yes' to each data element. A negative response by the HCC to any data element will cause a negative result to be reported for the coalition for that performance measure.



Why is this measure important?

This measure helps to ensure that local public health agencies and directly funded cities coordinate with leaders or officials who manage fatalities, as well as other jurisdictional partners, to develop a shared understanding of roles and responsibilities related to fatality management.



What other requirements are there for reporting measure data?

- Reporting for this measure is required for all awardees.
- Reporting for this measure is required at least annually, and at Mid-Year for BP 1.
- Awardees are expected to collect all data elements at the **HCC level**.



What data must be reported?

Data Element #1:

Has the HCC identified the roles and responsibilities of member organizations and other key partners for managing mass fatalities, including but not limited to the following:

- Identifying response actions of HCC members, including local health departments, local emergency management, hospitals, other HCOs, and other key partners (e.g., funeral directors, coroners, medical examiners).
- Identifying who is responsible for each of the Fatality Management functions.
- Identifying legal or regulatory authority of member organizations and key partners that govern fatality management in the local jurisdiction, including any necessary waivers (e.g. determining cause of death, identification and storage of remains, family notification, burial permits and vital records, etc.) .

Data Element #2:

Has the HCC established systems and processes to manage mass fatalities consistent with its defined roles and responsibilities, including but not limited to the following:

- Ensuring that systems and processes are aligned with the local jurisdictional EOP or fatality management plan.
- Identifying critical pathways or trigger points for response actions.
- Providing training on fatality management coordination.
- Establishing communication systems among members and key partners, including mental or behavioral health professionals.
- Developing concepts of operations and standard operating procedures.




Technical Assistance Guidance:

All of the processes associated with Fatality Management for the jurisdictions within its defined geographic regions must be written down.

The HCC plan must identify all HCC member organizations that have any assigned roles or responsibilities in these processes.

Any resources required for Fatality Management (FM) systems used in the FM process must be operational, with all components in place.

Data Element #3:

Has the HCC established systems and processes to manage a surge of concerned citizens requesting information about missing family members, including how to contact the responsible agency for family support, and protocols to ensure its HCOs can connect with family assistance and/or family reception centers?


Technical Assistance Guidance:

All of the processes associated with managing concerned citizens for the jurisdictions within its defined geographic regions must be written down.

The HCC plan must identify all roles and responsibilities in these fatality management processes assigned to its member hospitals, HCOs and governmental agencies.

Data Element #4:

Has the HCC successfully tested its systems and processes for managing mass fatalities during an exercise or event? Has this taken place within the past year?


Technical Assistance Guidance:

In order to respond that FM systems and processes were 'successfully tested', the test must have:

- Included triggering of each critical pathway defined in the FM plan for the HCC that is appropriate to the test design.
- Touched every system referenced by the process for those critical pathways.
- Included all key players having roles essential to the completion of FM processes.
- Although the HPP FOA requires that all hospitals and HCCs participate in at least one regional or statewide exercise over the 5-year grant period, an HCC must identify each year whether the HCC and its members have participated in an exercise or an event. The HCC is strongly encouraged to participate in a yearly exercise or event if the opportunity arises. If there was no event or exercise, it must score 'No' because of no opportunity.
 - The HCC does not have to be the lead organizer, but the HCC must participate as an operational entity.

Data Element #5:

Has the HCC successfully implemented "lessons learned" and corrective action from this exercise or event within the past year?


Technical Assistance Guidance:

The phrase "successfully" implemented as used in Data Element #5 refers to meeting the objectives specified in the drill or exercise.

It is an expectation that the HCC will be participating in regional exercises. As such, the HCC is responsible for successfully coordinating and identifying all issues and is expected to address all identified issues for which the HCC and its HCOs have control.



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The HCC and its HCOs are expected to establish realistic, measureable, and time-specific resolutions to mitigate items identified as part of the corrective actions. All corrective actions must be assigned a targeted completion date.

To score a 'Yes' for this data element, the HCC must have fully completed the outstanding corrective actions from its formal AAR and any other "lessons learned" that were due to be completed during the reporting period, within the time frames and at the level of correction and completion, specified by the HCC.

If there was no event or exercise, it must score 'No' because of no opportunity.



Putting the pieces together

- Identify the lead agency for Fatality Management for the HCC defined geographic region.
- Describe the roles and responsibilities of the HCC and its member organizations and other key partners for managing mass fatalities, corresponding family assistance and support needs, and systems and processes for managing concerned citizens.
- Describe HCC established systems and processes developed in relation to defined roles and responsibilities.
- Evaluate HCC systems and process for managing Fatality Management through tests and exercise.
- Identify and implement needed corrective actions resulting from tests and exercises that evaluate HCC systems and processes for managing Fatality Management.



Key Definitions

Family Assistance Center: a secure facility established to serve as a centralized location to provide information and assistance about missing or unaccounted for persons and deceased, and support the reunification of the missing or deceased with their loved ones.

Trigger: An event which initiates certain actions.

Mental or behavioral health professional: someone who offers services that have the effect of improving an individual's mental state, such as psychologists, social workers, therapists, counselors, spiritual care providers, hospice providers, and translators, or embassy and Consulate representatives when international victims are involved.



HPP 6.1: Information Sharing

Introduction

Information sharing is the ability to conduct multijurisdictional and multidisciplinary exchange of public health- and medical-related information and situational awareness data among Federal, State, local, territorial, and tribal levels of government and the private sector. This capability includes the routine sharing of information as well as issuing of public health alerts to Federal, State, local, Territorial, and Tribal levels of government and the private sector in preparation for, and in response to, events or incidents of public health significance. To integrate this capability, public health and healthcare emergency planners should coordinate what information is shared, who needs it, how it is delivered and when it should be provided. An effective information sharing system will provide durable, reliable, and effective information exchanges (both horizontally and vertically) between those responsible for gathering information and the analysts and consumers of threat or hazard-related information. It will also allow for feedback and other necessary communications in addition to the regular flow of information and intelligence.

Capability Functions

- **Provide healthcare situational awareness that contributes to the incident common operating picture**
- **Develop, refine, and sustain redundant, interoperable communication systems**

HPP 6.1: Information Sharing

Measure 6.1:

Percent of healthcare coalitions (HCCs) that can continuously monitor Essential Elements of Information (EEl)s and demonstrate the ability to electronically send data to and receive data from coalition members to inform a Common Operating Picture

Performance Target:

100% by the end of the project period (Year 1 data will be used to establish baselines)

Data Elements:

- Has the HCC identified essential elements of information (EEl)s that the HCC members must report for specific types of events to inform the common operating procedure?
- Has the HCC defined data usage and access policies for the EEl data?
- Does the HCC have redundant systems and processes in place to electronically send and receive the EEl data?
- Can the HCC share basic epidemiological and/or clinical data with relevant local health departments?
- Are the HCC members able to report the identified EEl)s electronically within the timeframe requested as evidenced by performance during exercises or events?
- Is the HCC able to receive and quickly process the EEl data to provide timely, relevant, and actionable healthcare information to the common operating picture as evidenced by performance during exercises or events?
- Have the HCC members successfully implemented lessons learned and corrective action from this exercise or event within the past year?



Thinking It Through

Key Questions

- What are the essential elements of information required by the local, regional, and State jurisdiction to coordinate situational awareness with the HCC and its member organizations (e.g. facility operating status, facility structural integrity, etc.)
- What are the established procedures, protocols, authorities, and permissions for EEl data and its use?
- Has the HCC provided for multiple ways to send and receive each type of EEl data to/from each HCO and key partner?
- Are there HCC procedures and information sharing agreements that enable it to share basic epidemiological/clinical data with health departments?
- Has the HCC identified appropriate means by which this information will be shared?
- Has the HCC identified triggers and appropriate means to initiate communication of EEl data?
- Has the HCC and its members participated in an exercise to initiate EEl data reporting?
- Can identified EEl data be shared through electronic reporting from each coalition member?



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Response



How is the measure calculated?

Numerator:

Number of HCCs that can continuously monitor Essential Elements of Information (EIs) and demonstrate the ability to electronically send data to and receive data from coalition members to inform a Common Operating Picture.

Denominator:

Number of HCCs identified by awardees.

Result Calculation:

In order for an awardee to report a positive result for the performance measure, the HCC must answer 'Yes' to each data element. A negative response by the HCC to any data element will cause a negative result to be reported for the coalition for that performance measure.



Why is this measure important?

To determine whether HCCs have the capability to maintain a Common Operating Picture during surge operations.



What other requirements are there for reporting measure data?

- Reporting for this measure is required for all awardees.
- Reporting for this measure is required at least annually, and at Mid-Year for BP 1
- Awardees are expected to collect all data elements at the **HCC level**.



What data must be reported?

Data Element #1:

Has the HCC identified EIs that the HCC members must report for specific types of events to inform the common operating procedure? Examples of EI data include:

- Facility operating status
- Facility structural integrity
- Status of evacuations or shelter in place operations
- Critical medical services (e.g., critical care, trauma)
- Critical service status (e.g., electric, water, sanitation, heating, ventilation, air conditioning)
- Critical healthcare delivery status (e.g., surge status, bed status, deaths, medical and pharmaceutical supply and medical equipment)
- Staffing status
- Emergency Medical Services status involving patient transport, tracking and availability
- Electronic patient tracking
- Electronic bed tracking



Technical Assistance Guidance:

EI lists should be defined for hazards included in an HVA conducted within the last 3 years, as well as a general-purpose list to be used for events not included in the HVA.

The HCC must coordinate with its HCOs, and the Federal, State and local governments to ensure that at a minimum the EI list contains all of the needed items identified to inform the common operating picture.

The HCC may add its own HCC-specific or desired items to its EI List.



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Data Element #2:

Has the HCC defined data usage and access policies for the EEI data?


Technical Assistance Guidance:

The HCC must coordinate with its HCOs, the State government, and the local government to address the following:

- Participants authorized to receive and share data
- Data use and re-release parameters
- Data Protection
- Legal, statutory, privacy, and intellectual property
- Information System Security

Data Element #3:

Does the HCC have redundant systems and processes in place to electronically send and receive the EEI data?


Technical Assistance Guidance:

The HCC does not have to be the owner of the systems; the systems have to be operational in the HCC's geographic region, and its members must have the ability to share data electronically across the HCC.

The secondary system is not required to be electronic but there has to be a redundant system in place.

Data Element #4:

Can the HCC share basic epidemiological and/or clinical data with relevant local health departments?


Technical Assistance Guidance:

The HCC's role is to facilitate communication of authorized data between its HCOs and the local health department.

The HCC's role is to ensure that its HCOs have access to authorized and available data and ensure that its HCOs have protocols for sharing data.

Hospitals in an HCC are expected to share case info for reportable diseases, share sentinel lab data and be as integrated as possible into the local Health Alert Network (HAN) or equivalent, consistent with Capability 3 Function 3.

Data Element #5:

Are the HCC members able to report the identified EEIs electronically within the timeframe requested as evidenced by performance during exercises or events?


Technical Assistance Guidance:

Although the HPP FOA requires that all hospitals and HCCs participate in at least one regional or statewide exercise over the 5-year grant period, an HCC must identify each year whether the HCC and its members have participated in an exercise or an event. The HCC is strongly encouraged to participate in a yearly exercise or event if the opportunity arises. If there was no event or exercise, it must score 'No' because of no opportunity.

The HCC does not have to be the lead organizer, but the HCC must participate as an operational entity.



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Data Element #6:

Is the HCC able to receive and quickly process the EEI data to provide timely, relevant, and actionable healthcare information to the common operating picture as evidenced by performance during exercises or events?


Technical Assistance Guidance:

Although the HPP FOA requires that all hospitals and HCCs participate in at least one regional or statewide exercise over the 5-year grant period, an HCC must identify each year whether the HCC and its members have participated in an exercise or an event. The HCC is strongly encouraged to participate in a yearly exercise or event if the opportunity arises. If there was no event or exercise, it must score 'No' because of no opportunity.

The HCC does not have to be the lead organizer, but the HCC must participate as an operational entity.

Data Element #7:

Have the HCC members successfully implemented "lessons learned" and corrective action from this exercise or event within the past year?


Technical Assistance Guidance:

The phrase "successfully" implemented as used in Data Element #7 refers to meeting the objectives specified in the exercise.

It is the expectation that the HCC will be participating in regional exercises. As such, the HCC is responsible for successfully coordinating and identifying all issues and is expected to address all identified issues for which the HCC and its HCOs have control.

The HCC and its HCOs are expected to establish realistic, measureable, and time-specific resolutions to mitigate items identified as part

of the corrective actions. All corrective actions must be assigned a targeted completion date.

To score a 'Yes' for this data element, the HCC must have fully completed the outstanding corrective actions from its formal AAR and any other "lessons learned" that were due to be completed during the reporting period, within the time frames and at the level of correction and completion, specified by the HCC.

If there was no event or exercise, it must score 'No' because of no opportunity.


Putting the pieces together

- Describe the identified EEIs for specific types of events to inform the common operating picture for the local, regional, or State jurisdiction.
- Describe data usage and access policies for identified EEI data for the HCC and its members.
- Summarize redundant systems and processes in place to electronically send and receive EEI data.
- Evaluate how effectively the HCC and its members are able to share EEI data with public health and other identified partners through tests and exercises to inform the common operating picture for the local, regional, or State jurisdiction .
- Identify and implement needed corrective actions resulting from tests and exercises that evaluate the HCC's ability to share EEI data to inform the common operating picture for the local, regional, or State jurisdiction.


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Key Definitions

Common Operating Picture: A single display or understanding of relevant operational information shared by more than one group, organization, or command.

Data Usage and Access Policies: Rules and guidelines specifying appropriate and inappropriate uses for different types of information, including legal, statutory, privacy, and intellectual property considerations, the types of information that can be shared and with whom, recommended data sharing frequency, and suggested or required data protections and information system security.



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HPP-PHEP 6.1: Information Sharing

Measure 6.2: Percent of local partners that submitted all requested Essential Elements of Information (EEI) to health and medical lead within the requested timeframe

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Reporting	<input checked="" type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Cities	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input checked="" type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input checked="" type="checkbox"/> Territories or Freely Associated States	<input checked="" type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input checked="" type="checkbox"/> Planned Event	<input checked="" type="checkbox"/> Data Collected By: HPP and/or PHEP



How is the measure calculated?

Numerator:

Number of local partners that submitted all requested EEI to the health and medical lead within the requested timeframe.

Denominator:

Number of local partners that received a request for EEI.

- Awardees should report the numerator and denominator of this measure by incident, planned event or exercise.
- Reporting should be based on an incident (preferred) and/or planned events and exercises
- Reporting on 2 operational periods over at least 2 incidents, if possible
- Reporting on 2 operational periods from at least 2 exercises or planned events if no incidents.



Why is this measure important?

The intent of this measure is to assess the extent to which local response entities communicate requested information to the health or medical lead in order to facilitate situational awareness and the effective management of resources in a timely manner.



What data must be reported?

1. Number of local partners that received a request for EEI (denominator).
2. Number of local partners that submitted all requested EEI to the health and medical lead within the requested timeframe (numerator).
3. The request for EEI occurred during a [Check one of the following]:
 - Incident
 - Full scale exercise
 - Functional exercise
 - Drill
 - Planned event



What other requirements are there for reporting measure data?

- Reporting for this measure is required for all awardees.
- Reporting for this measure is required annually.
- Reporting for this measure is required at mid-year and end-of-year for BP 1.



4. Please identify the type of incident, exercise, or planned event upon which the request for EEI was based [Check all that apply]:
 - Extreme weather (e.g., heat wave, ice storm)
 - Flooding
 - Earthquake
 - Hurricane or tropical Storm
 - Hazardous material
 - Fire
 - Tornado
 - Biological hazard or disease, please specify
 - Radiation
 - Other, please specify
5. Please provide the name and date of the incident, planned event, or exercise
6. Please state how many of each type(s) of local partners responded to the request:
 - HCOs
 - HCCs
 - LHDs
 - Other, please specify
7. Please identify the requesting entity (e.g., health and medical lead at the State, sub-state, regional, or local level). [Check one of the following]
 - State health and medical lead (or designee)
 - Sub-state regional health and medical lead (or designee)
 - Local health and medical lead (or designee)
 - Other, please specify
8. Please identify the types of EEI requested. [Check all that apply]
 - Facility operating status
 - Facility structural integrity
 - The status of evacuations or shelter in-place operations
 - Status of critical medical services (e.g., trauma, critical care)
 - Critical service or infrastructure status (e.g., electric, water, sanitation, heating, ventilation, and air conditioning)
 - Bed or patient status
 - Equipment, supplies, medications, vaccine status or needs
 - Staffing status
 - Emergency Medical Services (EMS) status
 - Epidemiological, surveillance or lab data (e.g., test results, case counts, deaths)
 - School-related data (closure, absenteeism, etc.)
 - POD or mass vaccination sites data (e.g., throughput, open or set-up status, etc.), please specify
 - Other, please specify
9. Please identify the type of IT or other communication system used to request EEI from local partners.
10. Please identify the type of IT or other communication system local partners used to submit requested EEI.
11. Barriers or challenges to submitting requested EEI within the requested timeframe (please describe types of local partners experiencing challenges and types of EEI not submitted within requested timeframe).



How is this measure operationalized?

This measure intends to capture information on the communication of incident-specific EEIs. Data elements for this measure should be based on: the incident commander’s determination of specifically required health and medical EEI for that incident (and tasked to the health and medical lead, or equivalent entity, to collect), specific local partners (i.e., entities that will report EEI to the incident commander or designee) and the requested timeframe determined by the incident commander or designee.



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HPP 10.1: Medical Surge

Introduction

Medical surge is the ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community. It encompasses the ability of the healthcare service delivery system to survive a hazard impact and maintain or rapidly recover operations that were compromised.

The goal is rapid and appropriate care for the injured or ill from the event and the maintenance of continuity of care for non-incident related illness or injury.

Capability Functions

- **The Healthcare Coalition assists with the coordination of the healthcare organization response during incidents that require medical surge**
- **Coordinate integrated healthcare surge operations with pre-hospital Emergency Medical Services (EMS) operations**
- **Assist healthcare organizations with surge capacity and capability**
- **Develop Crisis Standards of Care guidance**
- **Provide assistance to healthcare organizations regarding evacuation and shelter in place operations**

HPP 10.1: Medical Surge

Measure 10.1:

Percent of HCCs that have a coordinated mechanism established that supports their members' ability both to deliver appropriate levels of care to all patients (including pre-existing patients [both inpatient and outpatient], non-disaster-related patients, and disaster-specific patients), as well as to provide no less than 20% bed availability of staffed members' beds, within 4 hours of a disaster

Performance Target:

100% by the end of the project period (Year 1 data will be used to establish baselines)

Data Elements:

- Do the surge plans of the HCC hospitals and other HCC members include written clinical practice guidelines for Crisis Standards of Care for use in an incident, including triggers that delineate shifts in the continuum of care from conventional to crisis standards of care?
- Has the HCC successfully tested its coordinated mechanism to both deliver appropriate levels of care to all patients, as well as able to provide no less than 20% immediate availability of staffed members' beds, within 4 hours of a disaster?
- Has the HCC successfully implemented lessons learned and corrective action from this exercise or event within the past year?
- Has the HCC demonstrated the ability to communicate regional healthcare surge status in an exercise or event within the past year?
- Does the HCC have the ability to expand its coalition-wide surge capacity according to the scope and magnitude of the incident?

- Does the HCC have the ability to communicate and coordinate support to its member organizations so that members can perform surge functions and coordinate distribution of resources to support those functions?



Thinking It Through

Key Questions

- Have written Crisis Standards of Care been incorporated into HCC member hospitals surge plans?
- Does the HCC surge plan for its HCC hospitals and HCOs address surge relative to the baseline established in the Emergency Operations Coordination Measure 3, Data Element 2 against the following categories:
 - Diversion of patients to maintain
 - Capability or Capacity Building necessary to reach 20% beds above baseline
 - Decompression to achieve 20% of baseline "immediate" bed availability (IBA) (i.e., within 4 hours of disaster)
- Has the HCC demonstrated the ability to provide 20% bed availability through tests, exercise, or real events?
- Has the HCC coordinated with the local, regional, or State jurisdiction to define trigger conditions, which indicate the local healthcare response capability is insufficient and State or Federal response teams must be requested for activation?
- Has the HCC developed processes to communicate, send, or receive resource requests from its members and for locating resources to attempt to fill those requests?



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How is the measure calculated?

Numerator:

Number of HCCs that have a coordinated mechanism in place to provide an appropriate level of care to all patients (including pre-existing patients [both inpatient and outpatient], non-disaster-related patients, and disaster-specific patients) that includes providing bed availability 20% above the daily census within 4 hours of a disaster.

Denominator:

Number of HCCs identified by awardees.

Result Calculation:

In order for an awardee to report a positive result for the performance measure, the HCC must answer ‘Yes’ to each data element. A negative response by the HCC to any data element will cause a negative result to be reported for the coalition for that performance measure.



Why is this measure important?

To determine whether HCCs are prepared to provide healthcare in the immediate aftermath of a disaster. To ensure immediate bed availability in times of crisis, coalition partners must continuously monitor acuity of patients and maintain full ability for patient movement. Once a disaster happens, acute care facilities will need to prepare for an influx of new disaster patients. Through agreements with coalition partners, movement of lower acute patients begins from hospitals to other, appropriate facilities and care sites; thus making room for higher acuity patients. These same agreements ensure that receiving facilities are prepared to provide the appropriate level of care.



What other requirements are there for reporting measure data?

- Reporting for this measure is required for all awardees.
- Reporting for this measure is required at least annually, and at Mid-Year in BP 1
- Awardees should collect all data elements at the **HCC level**.



What data must be reported?

Data Element #1:

Do the surge plans of the HCC hospitals and other HCC members include written clinical practice guidelines for Crisis Standards of Care for use in an incident, including triggers that delineate shifts in the continuum of care from conventional to crisis standards of care?



Technical Assistance Guidance:

Crisis standards of care are a new area of planning emphasis in the HPP Cooperative Agreement. To provide the greatest good for the greatest number, and ensure that the response offers the best care possible given the resources at hand, there is a crucial interdependency between and among all HCC members in order to diminish the amount of death, injury or illness likely to result from a catastrophic event, in the absence of such planning.

As the HCC works with the State to implement local planning for Crisis Standards of Care, the HCC first and foremost is expected to collaborate with the State and with all of its members in the development of HCC triggers for shifting between various points in the continuum of care from conventional to crisis standards of care.

To score ‘Yes’ for this data element, the HCC must facilitate the development of this guidance about triggers that reflects the HCC’s view of the guidance described in the paragraph above, and

at a minimum at least the following HCC members must have been participants in developing that guidance:

- 100% of the HCC hospitals
- At least one long term care facility
- At least one EMS agency
- At least one community health center or a Federally Qualified Health Center (if either is represented by membership on the HCC)
 - At least one local health dept.
 - Representation from the remaining essential healthcare member partners, as applicable to the HCC (consistent with the membership guidance described in Capability 1, Function 1, P3 and P4 if applicable)

Data Element #2:

Has the HCC successfully tested its coordinated mechanism to both deliver appropriate levels of care to all patients, as well as able to provide no less than 20% immediate availability of staffed members’ beds, within 4 hours of a disaster?



Technical Assistance Guidance:

As used in data element#2 and throughout this implementation document, “immediate” is operationalized to mean ‘within 4 hours of a disaster’.

"All patients" as used in the measure and data elements is expected to include:

- pre-existing inpatients
- pre-existing outpatients
- non-disaster-related patients, and
- disaster-specific patients

In order to respond ‘Yes’ that decompression of beds was 'successfully tested,' the test must have identified the specific beds that could be made available. It is not necessary that these beds actually be made available, only that they are identified.

In order to respond ‘Yes’ that 'appropriate levels of care' were delivered, it must be demonstrated that the level of care provided both to the patients whose beds were made available for disaster victims as well as the disaster victims received levels of care consistent with the currently indicated level of care as determined by clinical guidelines contained in the adopted Crisis Standards of Care.

The time to be used to start counting the 4 hours is the time the notification was either issued by the HCC, or issued by the entity identified in the HCC's plan

The 20% can be distributed among HCC members as the HCC and its members have planned, if its plans are still applicable.

To score ‘Yes’ all members identified as a participant in the HCC’s coordinated plan must participate in the test.

Although the HPP FOA requires that all hospitals and HCCs participate in at least one regional or statewide exercise over the 5-year grant period, an HCC must identify each year whether the HCC and its members have participated in an exercise or an event. The HCC is strongly encouraged to participate in a yearly exercise or event if the opportunity arises. If there was no event or exercise, it must score ‘No’ because of no opportunity.

The HCC does not have to be the lead organizer, but the HCC must participate as an operational entity.

Data Element #3:

Has the HCC successfully implemented “lessons learned” and corrective action from this exercise or event within the past year?



Technical Assistance Guidance:

The phrase “successfully” implemented as used in Data Element #3 refers to meeting the objectives specified in the exercise.

It is the expectation that the HCC will be participating in regional exercises. As such, the HCC is responsible for successfully coordinating and identifying all issues and is expected to address all identified issues for which the HCC and its HCOs have control.

The HCC and its HCOs are expected to establish realistic, measurable, and time-specific resolutions to mitigate items identified as part of the corrective actions. All corrective actions must be assigned a targeted completion date.

To score a 'Yes' for this data element, the HCC must have fully completed the outstanding corrective actions from its formal AAR and any other "lessons learned" that were due to be completed during the reporting period, within the time frames and at the level of correction and completion, specified by the HCC.

If there was no event or exercise, it must score 'No' because of no opportunity.

Data Element #4:

Has the HCC demonstrated the ability to communicate regional healthcare surge status in an exercise or event within the past year?



Technical Assistance Guidance:

The ability to communicate Healthcare Surge status to the appropriate contact in the State or jurisdictional Emergency Operations Center (EOC) and/or Incident Command System (ICS) is critical. The HCC should be able to both send and receive information related to healthcare surge status. Surge status must address at least the following three (3) levels of surge relative to the baseline (i.e., the "normal resources to beds" number) identified in Measure 3, Data Element 2:

- Diversion of patients to maintain baseline
- Capability or Capacity Building necessary to reach 20% beds above baseline
- Decompression to achieve 20% of baseline "immediate" bed availability (i.e., within four-hours of a disaster)

Although the HPP FOA requires that all hospitals and HCCs participate in at least one regional or statewide exercise over the 5-year grant period, an HCC must identify each year whether the HCC and its members have participated in an exercise or an event. The HCC is strongly encouraged to participate in a yearly exercise or event if the opportunity arises. If there was no event or exercise, it must score 'No' because of no opportunity.

The HCC does not have to be the lead organizer, but the HCC must participate as an operational entity.

Data Element #5:

Does the HCC have the ability to expand its coalition-wide surge capacity according to the scope and magnitude of the incident?



Technical Assistance Guidance:

The scope and magnitude of the incident should include but not be limited to consideration of the surge need for:

- Medical Surge?
- Critical Care — Pediatrics?
- Critical Care — Adult?
- Pediatrics?
- Psychiatric?
- Burn?

The HCC or region should define trigger conditions, which indicate the local healthcare response capability is insufficient and State or Federal response teams must be requested for activation. This trigger must be formally agreed upon with the State.

The HCC should answer 'Yes' if it is able to surge to the maximum level that does not trigger a State-level response.

Although the HPP FOA requires that all hospitals and HCCs participate in at least one regional or statewide exercise over the 5-year grant period, an HCC must identify each year whether the



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HCC and its members have participated in an exercise or an event. The HCC is strongly encouraged to participate in a yearly exercise or event if the opportunity arises. If there was no event or exercise, it must score 'No' because of no opportunity.

The HCC does not have to be the lead organizer, but the HCC must participate as an operational entity.

Data Element #6:

Does the HCC have the ability to communicate and coordinate support to its member organizations so that members can perform surge functions and coordinate distribution of resources to support those functions?



Technical Assistance Guidance:

Surge Functions are expected to include but not be limited to:

- Registration and Triage?
- Emergency or Evaluation Services?
- Laboratory and Radiological Services?
- Durable Equipment?
- Pharmaceuticals?
- Consumable Supplies?
- Psychological Support?
- Housekeeping?
- Mortuary?
- Nutrition?

The HCC must have a process in place for receiving resource requests from its members and for locating resources to attempt to fill those requests.

Other than for regional caches, it is not necessary that the HCC directly broker resource sharing. However it is necessary that the HCC be informed either before or after the fact that resources have been redistributed.



Putting the pieces together

- Describe HCC and member HCO surge plans.
- Identify and describe written clinical practice guidelines for Crisis Standards of Care. Guidelines should apply to an incident across the continuum of care from conventional to crisis standards of care. These guidelines should be included in the HCC and member HCO surge plans.
- Evaluate how effectively the HCC and its members are able to demonstrate coordinated mechanisms to deliver appropriate levels of care to all patients and provide no less than 20% immediate bed availability of HCC members staffed hospital beds within 4 hours of a disaster.
- Identify and implement needed corrective actions resulting from tests and exercises that evaluate the HCC's ability to demonstrate coordinated mechanisms to deliver appropriate levels of care to all a patients.
- Evaluate the HCC's ability to communicate regional healthcare surge status through tests and exercises.
- Evaluate the HCC's ability to expand its coalition-wide surge capacity according to the scope and magnitude of the incident through tests and exercises.
- Describe HCC's process and systems in place to communicate and coordinate support to its member organizations.





Key Definitions

Immediate Bed Availability (IBA): IBA is the concept whereby coalition partners provide an appropriate level of care to non-disaster and disaster-related patients during declared disasters with public health implications, by availing 20% of staffed hospital beds to higher acuity patients within four (4) hours of a disaster and identifying and providing the appropriate care for lower-acuity patients.

Trigger: An event which initiates certain actions.

Regional Surge Planning: Surge planning with a group of healthcare organizations located within a specified geographic region (see definitions of Surge Capacity and Surge Capability below).

Surge: The state in which the capacity (volume of patients and requirements) and capabilities (the ability to treat or manage a medical condition) of a healthcare entity are above baseline requirements.

Surge Capability: The ability to manage patients requiring unusual or very specialized medical evaluation and care. Requirements span the range of specialized medical and public health services (expertise, information, procedures, equipment, or personnel) that are not normally available at the location where they are needed. It also includes patient problems that require special intervention to protect medical providers, other patients, and the integrity of the healthcare organization.

Surge Capacity: The ability to evaluate and care for a markedly increased volume of patients—one that challenges or exceeds normal operating capacity. Requirements may extend beyond direct patient care to include other medical tasks, such as extensive laboratory studies or epidemiologic investigations.

Crisis Standards of Care: At the request of the U.S. Department of Health and Human Services' Office of the Assistant Secretary for Preparedness and Response, the Institute of Medicine convened the *Committee on Guidance for Establishing Standards of Care for Use in Disaster Situations* to develop guidance that State and local public health officials can use to establish and implement standards of care that should apply in disaster situations—both naturally occurring and man-made—under scarce resource conditions. The resulting guidance is referred to as 'Crisis Standards of Care.'



HPP 14.1: Responder Safety and Health

Introduction

The responder safety and health capability describes the ability of healthcare organizations to protect the safety and health of healthcare workers from a variety of hazards during emergencies and disasters. This includes processes to equip, train, and provide other resources needed to ensure that healthcare workers at the highest risk for adverse exposure, illness, and injury, are adequately protected from all hazards during response and recovery operations. The goal is to assist healthcare organizations to ensure that no illnesses or injury occur to any first receiver, medical facility staff member, or other skilled support personnel as a result of preventable exposure to secondary trauma, chemical or radiological release, infectious disease, or physical and emotional stress after the initial incident or during decontamination and incident follow-up.

To integrate this capability, public health and healthcare emergency planners should coordinate how best to address public health and healthcare worker safety needs during the development of strategically placed caches of equipment, supplies and pharmaceuticals that would provide timely resource assistance. This is specifically outlined in the functions of Capability 14 from the *Healthcare Preparedness Capabilities* and cross-referenced to the Public Health Preparedness Capability.

Capability Functions

- Assist healthcare organizations with additional pharmaceutical protection for healthcare workers
- Provide assistance to healthcare organizations with access to additional Personal Protective Equipment (PPE) for healthcare workers during response

HPP 14.1: Responder Safety and Health

Measure 14.1:

Percent of HCCs that have systems and processes in place to preserve healthcare system functions and to protect all of the coalition member employees (including healthcare and non-healthcare employees)

Performance Target:

100% by the end of the project period (Year 1 data will be used to establish baselines)

Data Elements:

- Has the HCC implemented an occupational safety and health plan to protect employees of the organizations within the HCC and their families, based on an HVA conducted within the last 3 years?
- Do HCC member organizations have access to the elements of an occupational safety and health plan?
- Has the HCC successfully tested its systems and processes to preserve healthcare system functions and to enhance support of all HCC member employees (including healthcare and non-healthcare employees) in an exercise or event? Has this taken place within the past year?

- Has the HCC successfully implemented lessons learned and corrective actions from the exercise or event within the past year?



Thinking It Through

Key Questions

- Does the HCC have a responder safety and occupational health plan to preserve healthcare system function and protect HCC member employees?
 - Has the HCC designated a Safety Officer within the ICS for the local, regional, or State jurisdiction?
- How does the HCC continuously monitor responder safety and health resources, support and protections?
 - Proper functioning of PPE and equipment?
 - Awareness of on-site hazards?
 - Oversight of decontamination?
 - Documentation of all actions and injuries/illnesses?
 - Emergency and psychological medical care?
- What processes are in place to ensure HCC member organizations have access to responder safety and health resources, support and protections?
 - Has the HCC demonstrated the ability to maintain:
 - Continuous monitoring of responder safety and health?
 - Proper functioning of PPE and equipment?
 - Awareness of on-site hazards?
 - Oversight of decontamination?
 - Documentation of all actions and injuries/illnesses?
 - Emergency and psychological medical care?



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How is the measure calculated?

Numerator:

Number of HCCs that have systems and processes in place to preserve healthcare system functions and to protect all of the coalition member employees (including healthcare and non-healthcare employees).

Denominator:

Number of HCCs identified by awardees.

Result Calculation:

In order for an awardee to report a positive result for the performance measure, the HCC must answer ‘Yes’ to each data element. A negative response by the HCC to any data element will result in a negative answer ‘No’ for that performance measure.



Why is this measure important?

Working together as a coalition in responder safety planning can help to build resilience and reduce burden on individual hospitals. Such planning can determine whether healthcare organizations have access to sufficient protection to keep healthcare staff and others working effectively for the duration of a healthcare crisis.



What other requirements are there for reporting measure data?

- Reporting for this measure is required for all awardees.
- Reporting for this measure is required at least annually, and at Mid-Year in BP 1.
- Awardees should collect all data elements at the HCC level



What data must be reported?

Data Element #1:

Has the HCC implemented an occupational safety and health plan to protect employees of the organizations within the HCC and their families, based on an HVA conducted within the last 3 years?



Technical Assistance Guidance:

It is not necessary that the HCC sponsor its own occupational safety and health plan if member organizations have already implemented this function. The HCC is required to ensure that member HCOs have a process to enhance support and protections for healthcare workers and non-healthcare workers based on identified priorities and needs. As necessary, the HCC has a means to support its HCOs and other non-healthcare member organization’s access to the function through pooling resources among members.

Data Element #2:

Do HCC member organizations have access to the elements of an occupational safety and health plan that includes:

- Pharmaceutical caches
- PPE
- Medical countermeasures
- Risk communications
- Family member protections and considerations
- Social distancing protocols
- Behavioral health
- Security



Data Element #3:

Has the HCC successfully tested its systems and processes to preserve healthcare system functions and to enhance support of all HCC member employees (including healthcare and non-healthcare employees) in an exercise or event? Has this taken place within the past year?


Technical Assistance Guidance:

In order to respond that it has 'successfully tested' its Responder Safety Health (RSH) systems and processes, the test must have included triggering of each RSH element appropriate to the exercise or event and the triggered process must have successfully achieved its goal of enhancing support of HCC members' healthcare and non-healthcare workers.

Although the HPP FOA requires that all hospitals and HCCs participate in at least one regional or statewide exercise over the 5-year grant period, an HCC must identify each year whether the HCC and its members have participated in an exercise or an event. The HCC is strongly encouraged to participate in a yearly exercise or event if the opportunity arises. If there was no event or exercise, it must score 'No' because of no opportunity (Score = 5).

The HCC does not have to be the lead organizer, but the HCC must participate as an operational entity.

Data Element #4:

Has the HCC successfully implemented "lessons learned" and corrective actions from the exercise or event within the past year?


Technical Assistance Guidance:

The phrase "successfully" implemented as used in Data Element #4 refers to meeting the objectives specified in the exercise.

It is the expectation that the HCC will be participating in regional exercises. As such, the HCC is responsible for successfully coordinating and identifying all issues and is expected to address all identified issues for which the HCC and its HCOs have control.

The HCC and its HCOs are expected to establish realistic, measureable, and time-specific resolutions to mitigate items identified as part of the corrective actions. All corrective actions must be assigned a targeted completion date

To score a 'Yes' for this data element, the HCC must have fully completed the outstanding corrective actions from its formal AAR and any other "lessons learned" that were due to be completed during the reporting period, within the time frames and at the level of correction and completion, specified by the HCC.

If there was no event or exercise, it must score 'No' because of no opportunity.


Putting the pieces together

- Describe components of the HCC occupational safety and health plan.
- Identify points of contact for occupational safety and health described in the HCC occupational safety and health plan.
- Locate information on recent exercises in which the coalition or member HCOs participated.
- Evaluate the effectiveness of the HCC systems and processes to preserve healthcare system functions and to enhance support of all HCC member employees through tests and exercises.
- Identify and implement needed corrective actions resulting from tests and exercises that evaluate the effectiveness of the HCC's systems and processes to preserve healthcare system functions and to enhance support of all HCC member employees through tests and exercises.


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Key Definitions

Pharmaceutical Cache: A collection of pharmaceuticals, antidotes, and medical supplies designed to provide rapid delivery of a broad spectrum of assets for an ill-defined threat in the early hours of an event.

Prophylactic pharmaceutical caches can protect healthcare workers from illness, allowing them to continue delivering important healthcare services. In addition, providing prophylaxis to healthcare workers' families enhances response by theoretically allowing the worker to remain on duty rather than care for an ill family member.

Healthcare Workers' Families: Family members of healthcare workers who may benefit from prophylaxis or treatment theoretically allowing the worker to remain on duty rather than care for ill family members.

Prophylaxis: A medical or public health procedure undertaken to prevent, rather than treat or cure, a disease.

Post-exposure Prophylaxis: Treatment started immediately after exposure to a pathogen to prevent infection by the pathogen and the development of disease.

Personal Protective Equipment (PPE): Specialized clothing or equipment worn by an employee for protection against infectious materials. PPE such as masks and gloves can protect healthcare workers from illness and injury allowing them to continue delivering important healthcare services. Ensuring a sufficient supply of PPE requires a number of steps be taken during emergency preparedness including: determining the PPE need, assessing in-facility stocks of PPE, comparing need and stock to identify any PPE gaps, and then developing procedures for obtaining the gap amount should you need it (e.g., a resource request via the ICS resource management system).

Surge: The state in which the capacity (volume of patients and requirements) and capabilities (the ability to treat or manage a medical condition) of a healthcare entity are above baseline requirements.

Surge Capability: The ability to manage patients requiring unusual or very specialized medical evaluation and care. Requirements span the range of specialized medical and public health services (expertise, information, procedures, equipment, or personnel) that are not normally available at the location where they are needed. It also includes patient problems that require special intervention to protect medical providers, other patients, and the integrity of the healthcare organization.

Surge Capacity: The ability to evaluate and care for a markedly increased volume of patients—one that challenges or exceeds normal operating capacity. Requirements may extend beyond direct patient care to include other medical tasks, such as extensive laboratory studies or epidemiologic investigations.



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HPP 15.1: Volunteer Management

Introduction

Volunteer management is the ability to coordinate the identification, recruitment, registration, credential verification, training, engagement, and retention of volunteers to support healthcare organizations with medical preparedness and response to incidents and events.

To integrate this capability, public health and healthcare emergency planners should coordinate with healthcare organizations to determine when and why volunteers would be used to supplement staff at healthcare organizations and then work towards strategies for their effective use. This is specifically outlined in the functions of Capability 15 from the Healthcare Preparedness Capability and cross-referenced to the Public Health Preparedness Capability.

Capability Functions

- **Participate with volunteer planning processes to determine the need for volunteers in healthcare organizations**
- **Volunteer notification for healthcare response needs**
- **Organization and assignment of volunteers**
- **Coordinate the demobilization of volunteers**

HPP 15.1: Volunteer Management

Measure 15.1:

Percent of HCCs that have plans, processes and procedures in place to manage volunteers supporting a public health or medical incident.

Performance Target:

100% by the end of the project period (Year 1 data will be used to establish baselines)

Data Elements:

- Does the HCC have procedures for identifying the type and quantity of volunteers needed to support healthcare response?
- Does the HCC have or have access to an electronic registration system for recording and managing volunteer information that is compliant with the current guidelines of the HHS Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) program?
- Has the HCC coordinated with the State and HCC members to develop plans, processes and procedures to manage volunteers?
- Has the HCC successfully tested its plans, processes and procedures for managing volunteers during an exercise or event? Has this taken place within the past year?
- Has the HCC successfully implemented lessons learned and corrective action from this exercise or event within the past year?



Thinking It Through

Key Questions

- What are the staffing shortfalls that could be filled by volunteers in the event of a disaster?
- What resources are available through partners (e.g., rapid verification of credentials)?
- Does the HCC have access to an electronic system capable of registering and verifying the credentials of healthcare volunteers?
- Does the HCC have a process in place to ensure that volunteer management functions are fulfilled?
- Has the HCC demonstrated the ability to:
 - Receive volunteers
 - Determine volunteer affiliation
 - Confirm volunteer credentials
 - Assign roles and responsibilities to volunteers
 - Provide just in time training for volunteers
 - Track volunteers
 - Out-process volunteers



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How is the measure calculated?

Numerator:

Number of HCCs that have plans, processes and procedures in place to manage volunteers supporting a public health or medical incident

Denominator:

Number of HCCs identified by awardees

Result Calculation:

In order for an awardee to report a positive result for the performance measure, the HCC must answer 'Yes' to each data element. A negative response by the HCC to any data element will cause a negative result to be reported for the coalition for that performance measure.



Why is this measure important?

Implementation of volunteer management ensures that the HCC has developed its own or has access to plans, processes, and procedures to manage volunteers, including rapid verification of credentials and affiliation with deploying entities.



What other requirements are there for reporting measure data?

- Reporting for this measure is required for all awardees.
- Reporting for this measure is required at least annually, and at Mid-Year in BP 1.
- Awardees are expected to collect all data elements at the **HCC level**



What data must be reported?

Data Element #1:

Does the HCC have procedures for identifying the type and quantity of volunteers needed to support healthcare response?

Data Element #2:

Does the HCC have or have access to an electronic registration system for recording and managing volunteer information that is compliant with the current guidelines of the US Department of Health and Human Services (HHS) ESAR-VHP program?

Data Element #3:

Has the HCC coordinated with the State and its HCC members to develop plans, processes and procedures to manage volunteers that address the following areas:

- Receiving volunteers
- Determining volunteer affiliation, including procedures for integrating or referring non-registered or spontaneous volunteers
- Confirming volunteer credentials
- Assigning roles and responsibilities to volunteers
- Providing “just in time” training for volunteers
- Tracking volunteers
- Out-processing volunteers



Technical Assistance Guidance:

It is not necessary that the HCC own these functions, however the HCC must confirm the fulfillment of the following:

- The HCC develops its own procedures itself.
- Individual members develop all of these processes, and the HCC serves in a coordinative role.
- The processes are developed as part of a larger, greater ESF-8 plan.

Data Element #4:

Has the HCC successfully tested its plans, processes and procedures for managing volunteers during an exercise or event? Has this taken place within the past year?



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Technical Assistance Guidance:

The phrase “successfully” tested as used in Data Element #4 refers to meeting the objectives specified in the drill or exercise.

Volunteers must actually deploy for the exercise.

Although the HPP FOA requires that all hospitals and HCCs participate in at least one regional or statewide exercise over the 5-year grant period, an HCC must identify each year whether the HCC and its members have participated in an exercise or an event. The HCC is strongly encouraged to participate in a yearly exercise or event if the opportunity arises. If there was no event or exercise, it must score ‘No’ because of no opportunity.

The HCC does not have to be the lead organizer, but the HCC must participate as an operational entity.

Data Element #5:

Has the HCC successfully implemented “lessons learned” and corrective action from this exercise or event within the past year?


Technical Assistance Guidance:

The phrase “successfully” implemented as used in Data Element #5 refers to meeting the objectives specified in the drill or exercise.

It is the expectation that the HCC will be participating in regional exercises. As such, the HCC is responsible for successfully coordinating and identifying all issues and is expected to address all identified issues for which the HCC and its HCOs have control.

The HCC and its HCOs are expected to establish realistic, measureable, and time-specific resolutions to mitigate items identified as part of the corrective actions. All corrective actions must be assigned a targeted completion date.

To score a ‘Yes’ for this data element, the HCC must have fully completed the outstanding corrective actions from its formal AAR and any other “lessons learned” that were due to be completed during the reporting period, within the time frames and at the level of correction and completion, specified by the HCC.

If there was no event or exercise, it must score ‘No’ because of no opportunity.


Putting the pieces together

- Identify points of contact for local volunteer coordination.
- Describe HCC rights, roles, and access to an electronic registration system for recording and managing volunteer information.
- Describe coordination activities with the State and HCC members to develop plans, processes and procedures to manage volunteers.
- Evaluate the HCC’s plans, processes and procedures for managing volunteers through tests and exercises.
- Identify and implement needed corrective actions resulting from tests and exercises that evaluate the HCC’s plans, processes and procedures for managing volunteers.





Key Definitions

Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP):

A Federal program created to support State, local, territorial and tribal governments in establishing standardized volunteer registration programs for disasters and public health and medical emergencies. The program, administered on the State level, verifies health professionals' identification and credentials so that they can respond more quickly when disaster strikes. By registering through ESAR-VHP, volunteers' identities, licenses, credentials, accreditations, and hospital privileges are all verified in advance, saving valuable time in emergency situations.

Healthcare Coalition (HCC): The HCC is a collaborative network of healthcare organizations and their respective public and private sector response partners that serve as a multiagency coordinating group to assist with preparedness, response, recovery, and mitigation activities related to healthcare organization disaster operations. The primary function of the HCC includes sub-state regional, healthcare system emergency preparedness activities involving the member organizations. This includes planning, organizing and equipping, training, exercises and evaluation. During response, HCCs should represent healthcare organizations by providing multi-agency coordination in order to provide advice on decisions made by incident management regarding information and resource coordination for healthcare organizations. This includes either a response role as part of a multi-agency coordination group to assist incident management (area command or unified command) with decisions, or through coordinated plans to guide decisions regarding healthcare organization support.



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HPP-PHEP 15.1: Volunteer Management

Proportion of volunteers deployed to support a public health or medical incident within the requested timeframe

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input type="checkbox"/> Annual Reporting	<input checked="" type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Cities	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input checked="" type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input checked="" type="checkbox"/> Territories or Freely Associated States	<input checked="" type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input checked="" type="checkbox"/> Planned Event	<input checked="" type="checkbox"/> Data Collected By: HPP and/or PHEP



How is the measure calculated?

Numerator:

Number of volunteers deployed to support a public health or medical incident within the requested timeframe.

Denominator:

Number of volunteers requested to deploy in support of a public health or medical incident within the requested timeframe.



Why is this measure important?

The immediate intent of this measure is to assess the timeliness of implementing key stages of volunteer management — from receipt of request, to activation of volunteers, to deployment — in order to determine key bottlenecks and chokepoints which inhibit timely deployment of volunteers.

The broader programmatic intent of this measure is to ensure that the health or medical lead meets requests for volunteers in a timely manner.

This measure is NOT intended to assess routine or day-to-day volunteer activities in healthcare organizations.



What other requirements are there for reporting measure data?

- Reporting for this measure is required for all awardees.
- Reporting for this measure is required annually.
- Reporting for this measure is required at mid-year and end-of-year for BP 1.
- Awardees may report the numerator and denominator of this measure *by incident, planned event or exercise* at the State, sub-state regional or local level.
- For the purposes of reporting, awardees should include at least two incidents, exercises, or planned events. Across all incidents, exercises, or planned events reported, HPP and PHEP Volunteer Management capabilities must each be utilized or demonstrated at least once.



Pre-Incident

Healthcare Preparedness

Response



What data must be reported?

For each incident, planned event, or exercise reported on, please answer the following questions.

1. The request for volunteers occurred during a [Check one of the following]:
 - Incident
 - Full Scale Exercise
 - Functional Exercise
 - Drill
 - Planned event
2. This incident, planned event, or exercise utilized or demonstrated one or more function(s) within the: [Check one of the following]
 - HPP Volunteer Management Capability
 - PHEP Volunteer Management Capability
 - Both HPP and PHEP
3. The type of incident, exercise, or planned event upon which the request for volunteers was based (check all that apply):
 - Extreme weather (e.g., heat wave, ice storm, etc.)
 - Flooding
 - Earthquake
 - Hurricane or Tropical Storm
 - Hazardous Material
 - Fire
 - Tornado
 - Biological hazard or disease, please specify
 - Radiation
 - Other, please specify
4. The name and date of the incident, planned event, or exercise
5. The date and time when request for volunteers was received by health or medical lead.
6. The number of volunteers requested to deploy from the originating requestor (denominator).
7. The entity that made the original request for volunteers [Check one of the following]
 - Local health department
 - State health department
 - Healthcare organization
 - HCC
 - Other, please specify
8. The date and time when volunteers were requested to arrive at staging area or on scene by health and medical lead
9. The requested location for the deployment [Check one of the following]:
 - Staging or assembly area(s) (not actual incident site)
 - Hospital(s)
 - Shelter(s)
 - POD(s)
 - Alternate care site(s), please specify
 - Other, please specify
10. The number of volunteers who were notified to deploy (“activated”).
11. The date and time when the last volunteer was notified to deploy (i.e., “activated”).
12. The number of volunteers who arrived at staging area or “on scene” within requested timeframe (numerator):
 - a) Number of deployed volunteers registered in ESAR-VHP
 - b) Number of deployed volunteers registered in other systems
13. Date and time that last volunteer arrived at staging area or “on scene” within requested timeframe.
14. Barriers or challenges to deploying volunteers to support a public health or medical incident within requested timeframe.



Pre-Incident

Healthcare Preparedness

Response



How is this measure operationalized?

NOTE: The “**start time**” for this measure refers to the date and time that the health and medical lead at the local, regional, or State level receives a request for volunteers. The “**stop time**” for this measure refers to the time that the last requested volunteer arrives at a staging area or on scene, but no later than the requested timeframe.

Awardees are encouraged to report on one (1) long running and one (1) acute incident during the budget period, if possible. The awardee may also report on two (2) long running or two (2) acute incidents as an option. If neither of these is possible, reporting on two (2) exercises or planned events is permissible.



APPENDICES



Appendix A: Glossary

Business continuity: The ability of an organization to provide service and support for its customers and to maintain its viability before, during, and after a business continuity event.

Chain of command: The orderly line of authority within the ranks of the incident management organization.

Charter: A written instrument that creates or defines an organization and describes the organization's functions.

Common Operating Picture (COP): A common operating picture offers a standard overview of an incident, thereby providing incident information that enables the Incident Commander or Unified Command and any supporting agencies and organizations to make effective, consistent, and timely decisions. Compiling data from multiple sources and disseminating the collaborative information COP ensures that all responding entities have the same understanding and awareness of incident status and information when conducting operations. (*FEMA Communications and Information Management: <http://www.fema.gov/emergency/nims/CommunicationsInfoMngmnt.shtml>*)

Continuity of Operations Plans (COOP): A description of how personnel, equipment, and other governmental, non-governmental, and private resources will support the sustainment and/or reestablishment of essential functions. Plans shall identify the critical and time sensitive applications, processes, and functions, to be recovered and continued, following an emergency or disaster, as well as the personnel and procedures necessary to do so, such as business impact analysis, business continuity management, vital records preservation and alternate operating facilities. (*Reference Target Capabilities List (TCL) <http://www.fema.gov/pdf/government/training/tcl> pg. 23*)

Crisis Standards of Care: The level of care possible during a crisis or disaster due to limitations in supplies, staff, environment, or other factors. These standards will usually incorporate the following principles: (1) prioritize population health rather than individual outcomes; (2) respect ethical principles of beneficence, stewardship, equity, and trust; (3) modify regulatory requirements to provide liability protection for healthcare providers making resource allocation decisions; and/or (4) designate a crisis triage officer and include provisions for palliative care in triage models for scarce resource allocation (e.g., ventilators) (Chang et al., 2008). Crisis standards of care will usually follow a formal declaration or recognition by State government during a pervasive (pandemic influenza) or catastrophic (earthquake, hurricane) disaster which recognizes that contingency surge response strategies (resource-sparing strategies) have been exhausted, and crisis medical care must be provided for a sustained period of time. Formal recognition of these austere operating conditions enables specific legal or regulatory powers and protections for healthcare provider allocation of scarce medical resources and for alternate care facility operations. Under these conditions, the goal is still to supply the best care possible to each patient. (*Healthcare Preparedness Capabilities*)

Critical Infrastructure (CI) and Key Resources (KR): The assets, systems, networks, and functions, whether physical or organizational, whose destruction or incapacity would have a debilitating impact on the Nation's security, public health and safety, and/or economic vitality. (*Healthcare Preparedness Capabilities*)

Data Usage and Access Policies: Rules and guidelines specifying appropriate and inappropriate uses for different types of information, including: legal, statutory, privacy, and intellectual property considerations; the types of information that can be shared and with whom; recommended data sharing frequency; and suggested or required data protections and information system security.

Emergency operations coordination: Direction and support of an incident with public health or medical implications by establishing a standardized, scalable system of oversight, organization, and supervision consistent with jurisdictional standards and practices and with the National Incident Management System (NIMS).

Emergency Operations Plan (EOP): An ongoing plan for responding to a wide variety of potential hazards.

Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP): The Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) is a Federal program created to support State, local, territorial and tribal governments in establishing standardized volunteer registration programs for disasters and public health and medical emergencies. The program, administered on the State level, verifies health professionals' identification and credentials so that they can respond more quickly when disaster strikes. By registering through ESAR-VHP, volunteers' identities, licenses, credentials, accreditations, and hospital privileges are all verified in advance, saving valuable time in emergency situations.

Emergency Support Function (ESF) #8: Emergency Support Function (ESF) #8 — Public Health and Medical Services, provides the mechanism for coordinated Federal assistance to supplement State, tribal, and local resources in response to a public health and medical disaster, potential or actual incidents requiring a coordinated Federal response, and/or during a developing potential health and medical emergency. The phrase “medical needs” is used throughout this annex. Public Health and Medical Services include responding to medical needs associated with mental health, behavioral health, and substance abuse considerations of incident victims and response workers. Services also cover the medical needs of members of the “at risk” or “special needs” population described in the Pandemic and All-Hazards Preparedness Act and in the National Response Framework (NRF) Glossary, respectively. It includes a population whose members may have medical and other functional needs before, during, and after an incident. (*Healthcare Preparedness Capabilities*)

Exercise: The process of conducting activities involved with prevention, protection, response, and recovery capabilities in a risk-free environment. Exercises can be used for: testing and validating policies, plans, procedures, training, equipment, and inter-agency agreements; clarifying and training personnel in roles and responsibilities; improving interagency coordination and communications; identifying gaps in resources; improving individual performance; and identifying opportunities for improvement. (Note: An exercise is also an excellent way to demonstrate community resolve to prepare for disastrous events). (*Homeland Security Exercise and Evaluation Program Volume I: HSEEP Overview and Exercise Program Management*)

Family Assistance Center: A secure facility established to serve as a centralized location to provide information and assistance about missing or *unaccounted for* persons and the deceased, and support the reunification of the missing or deceased with their loved ones.

Fatality Management: The ability to coordinate with organizations (e.g., law enforcement, healthcare, emergency management, and medical examiner or coroner) to ensure the proper recovery, handling, identification, transportation, tracking, storage, and disposal of human remains and personal effects; certify cause of death; and facilitate access to mental or behavioral health services for family members, responders, and survivors of an incident. Coordination also includes the proper and culturally sensitive storage of human remains during periods of increased death surges.

Hazard Vulnerability Assessment (HVA): A systematic approach to recognizing hazards that may affect demand for services or the ability to provide those services. The risks associated with each hazard are analyzed to prioritize planning, mitigation, response, and recovery activities. An HVA serves as a needs assessment and a strategy to identify those hazards that are most likely to have an impact on a facility and the surrounding community. The HVA process should involve community partners and be communicated to community emergency response agencies. (*DHHS, 2009*).

Healthcare Coalition (HCC): The HCC is a collaborative network of healthcare organizations and their respective public and private sector response partners that serve as a multiagency coordinating group to assist with preparedness, response, recovery, and mitigation activities related to healthcare organization disaster operations. The primary function of the HCC includes sub-state regional, healthcare system emergency preparedness activities involving the member organizations. This includes planning, organizing and equipping, training, exercises and evaluation. During response, HCCs should represent healthcare organizations by providing multi-agency coordination in order to provide advice on decisions made by incident management regarding information and resource coordination for healthcare organizations. This includes either a response role as part of a multi-agency coordination group to assist incident management (area command or unified command) with decisions, or through coordinated plans to guide decisions regarding healthcare organization support. (*Healthcare Preparedness Capabilities*)

Healthcare Organization(s) (HCOs): The component(s) of a community's healthcare service delivery system to primarily include hospitals, Emergency Medical Services (EMS), primary care, long term care, mental or behavioral health systems, specialty services (dialysis, pediatrics, woman's health, standalone surgery, urgent care, etc.), support services (laboratories, pharmacies, blood banks, poison control, etc.), private entities associated with healthcare delivery (Hospital associations, regulatory boards, etc.). HCOs may or may not include components of public health, tribal healthcare, Federal (VA hospitals, IHS facilities, etc.), community health centers, volunteer medical organizations (e.g. ARC), DOD healthcare, Healthcare services provided in city, county, or State jails, prisons, penitentiaries and others not noted. (*Healthcare Preparedness Capabilities*)

Healthcare Constituencies: The people involved in or served by the HCC.

Healthcare Recovery: Locally-led recovery efforts in the restoration of the public health, health care and social services networks to promote the resilience, health and well-being of affected individuals and communities (adapted from http://www.fema.gov/pdf/recoveryframework/health_social_services_rsf.pdf).

Healthcare System or Healthcare Service Delivery System: A collection of a community's healthcare organizations. (*Healthcare Preparedness Capabilities*)

Healthcare Workers' Families: Family members of healthcare workers who may benefit from prophylaxis or treatment theoretically allowing the worker to remain on duty rather than having to care for ill family members.

Incident Command Structure (ICS): The Incident Command System (ICS) is a standardized, on-scene, all-hazards incident management approach that allows for the integration of facilities, equipment, personnel, procedures and communications operating within a common organizational structure, Enables

a coordinated response among various jurisdictions and functional agencies, both public and private, and establishes common processes for planning and managing resources (<http://www.fema.gov/incident-command-system#item1>).

Immediate Bed Availability (IBA): IBA is the concept whereby coalition partners provide an appropriate level of care to patients (non-disaster and disaster-related patients) during declared disasters with public health implications, by availing 20% of staffed hospital beds to higher acuity patients within four (4) hours of a disaster and identifying and providing the appropriate care for lower acuity patients.

Information Sharing: The ability to conduct multijurisdictional and multidisciplinary exchange of public health and medical-related information and situational awareness data among Federal, State, local, territorial, and tribal levels of government and the private sector. This capability includes the routine sharing of information as well as issuing of public health alerts to Federal, State, local, territorial, and tribal levels of government and the private sector in preparation for, and in response to, events or incidents of public health significance. An effective information sharing system will provide durable, reliable, and effective information exchanges (both horizontally and vertically) between those responsible for gathering information and the analysts and consumers of threat or hazard-related information. It will also allow for feedback and other necessary communications in addition to the regular flow of information and intelligence.

Interagency Agreement (IAA): A written agreement between Federal agencies or components of Federal agencies to acquire supplies or services as authorized by statute.

Key Partners: Within the context of Fatality Management, private organizations that have agreed to play a role in performing Fatality Management functions, such as funeral directors, coroners, medical examiners, or mental health professionals.

Medical Surge: The ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community. It encompasses the ability of the healthcare service delivery system to survive a hazard impact and maintain or rapidly recover operations that were compromised.

Memoranda of Understanding (MOUs) or Memoranda of Agreement (MOAs): Documents that describe a bilateral or multilateral agreement between two or more parties. These documents express an intended common line of action, establish a scope of association, and define mutual responsibilities. They are often used in cases where parties do not wish to or cannot create an otherwise legally enforceable agreement.

Mental or Behavioral Health Professional: Someone who offers services that have the effect of improving an individual's mental state, such as psychologists, social workers, therapists, counselors, spiritual care providers, hospice providers, and translators, or embassy and Consulate representatives when international victims are involved.

Mutual Aid Agreements (MAAs): A document that formalizes and defines the reciprocal assistance that two or more communities or organizations can and will provide to another in the event of a disaster.

Personal Protective Equipment (PPE): Specialized clothing or equipment worn by an employee for protection against infectious materials. PPE such as masks and gloves can protect healthcare workers from illness and injury allowing them to continue delivering important healthcare services. Ensuring a sufficient supply of PPE requires a number of steps be taken during emergency preparedness including: determining the PPE need, assessing in-facility stocks of PPE, comparing need and stock to identify any PPE gaps, and then developing procedures for obtaining the gap amount should you need it (e.g., a resource request via the ICS resource management system).

Pharmaceutical Cache: A collection of pharmaceuticals, antidotes, and medical supplies designed to provide rapid delivery of a broad spectrum of assets for an ill-defined threat in the early hours of an event. Prophylactic pharmaceutical caches can protect healthcare workers from illness, allowing them to continue delivering important healthcare services. In addition, providing prophylaxis to healthcare workers' families enhances response by theoretically allowing the worker to remain on duty rather than having to care for an ill family member.

Prophylaxis: A medical or public health procedure undertaken to prevent, rather than treat or cure, a disease.

Recovery Processes: Those capabilities necessary to assist communities affected by an incident to recover effectively, including, but not limited to, rebuilding infrastructure systems; providing adequate interim and long-term housing for survivors; restoring health, social, and community services; promoting economic development; and restoring natural and cultural resources (<http://www.fema.gov/pdf/recoveryframework/ndrf.pdf>). Examples include: the development, coordination, and execution of service- and site-restoration plans; the reconstitution of government operations and services; individual, private-sector, nongovernmental, and public assistance programs to provide housing and promote restoration; long-term care and treatment of affected persons; additional measures for social, political, environmental, and economic restoration; evaluation of the incident to identify "lessons learned"; post incident reporting; and development of initiatives to mitigate the effects of future incidents.

Resilience: The ability of an asset, system, network or function, to maintain its capabilities and function during and in the aftermath of an all-hazards incident. (*Healthcare Preparedness Capabilities*)

Situational Awareness: The ability to identify, process, and comprehend the essential information about an incident to inform the decision making process in a continuous and timely cycle and includes the ability to interpret and act upon this information.

Supply Chain: A system of organizations, people, technology, activities, information, and resources involved in moving a product or service from supplier to customer.

Surge Capacity: The ability to evaluate and care for a markedly increased volume of patients—one that challenges or exceeds normal operating capacity. Requirements may extend beyond direct patient care to include other medical tasks, such as extensive laboratory studies or epidemiologic investigations.

Trigger: An event which initiates certain actions.

Appendix B: PHEP Alignment Chart

The table below details the alignment of the HPP and HPP-PHEP Performance Measures with the HPP and PHEP preparedness capabilities.

Measures	Healthcare Preparedness Capabilities	Public Health Preparedness Capabilities
HPP 1.1	Healthcare System Preparedness	Community Preparedness
HPP 2.1	Healthcare System Recovery	Community Recovery
HPP 3.1	Emergency Operations Coordination	Emergency Operations Coordination
		Emergency Public Information and Warning
HPP 5.1	Fatality Management	Fatality Management
HPP.6.1	Information Sharing *	Information Sharing
HPP-PHEP 6.1		Mass Care
		Medical Countermeasure Dispensing
		Medical Materiel Management and Distribution
HPP 10.1	Medical Surge	Medical Surge
		Non-pharmaceutical Interventions
		Public Health Laboratory Testing
		Public Health Surveillance and Epidemiological Investigation
HPP 14.1	Responder Safety and Health	Responder Safety and Health
HPP 15.1	Volunteer Management *	Volunteer Management
HPP-PHEP 15.1		

* Aligned Capabilities with HPP-PHEP aligned performance measures.

Appendix C: Resource Element Map

Function	At least one measure maps to some aspect of this function	Resource Element	Number of measures that map to the resource elements	HPP Measures							HPP-PHEP Measures	
				1.1	2.1	3.1	5.1	6.1	10.1	14.1	15.1	6.1
Healthcare System Preparedness												
Function 1: Develop, refine, or sustain Healthcare Coalitions	TRUE	Healthcare Coalition regional boundaries	0									
		Healthcare Coalition primary members	1	X								
		Healthcare Coalition essential partner memberships	1	X								
		Additional Healthcare Coalition partnerships/ memberships	1	X								
		Healthcare Coalition organization and structure	1	X								
		Multi-agency coordination during response	3				X	X	X			
Function 2: Coordinate healthcare planning to prepare the healthcare system for a disaster	TRUE	Healthcare system situational assessments	1						X			
		Healthcare System disaster planning	3	X	X		X					
Function 3: Identify and prioritize essential healthcare assets and services	TRUE	Identify and prioritize critical healthcare assets and essential services	3		X	X		X				
		Priority healthcare assets and essential services planning	3		X	X		X				
		Equipment to assist healthcare organizations with the provision of critical services	2					X	X			
Function 4: Determine gaps in the healthcare preparedness and identify resources for mitigation of these gaps	TRUE	Healthcare resource assessment	3	X				X	X			
		Healthcare resource coordination	2	X					X			
		Address healthcare information gaps	2					X			X	

Function	At least one measure maps to some aspect of this function	Resource Element	Number of measures that map to the resource elements	HPP Measures									HPP-PHEP Measures	
				1.1	2.1	3.1	5.1	6.1	10.1	14.1	15.1	6.1	15.1	
Function 5: Coordinate training to assist healthcare responders to develop the necessary skills in order to respond	FALSE	Healthcare organization — National Incident Management System (NIMS) training	0											
		Training to address healthcare gaps and corrective actions	0											
Function 6: Improve healthcare response capabilities through coordinated exercise and evaluation	TRUE	Exercise plans	1		X									
		Exercise implementation and coordination	1	X										
		Evaluation and improvement plans	0											
		Best practice and “lessons learned” sharing	8	X	X	X	X	X	X	X	X			
Exercise and evaluation training	0													
Function 7: Coordinate with planning for at-risk individuals and those with special medical needs	FALSE	Healthcare planning for at-risk individuals and functional needs	0											
		Special medical needs planning	0											
Healthcare System Recovery														
Function 1: Develop recovery processes for the healthcare delivery system	TRUE	Healthcare recovery planning	3	X	X	X								
		Assessment of healthcare delivery recovery needs post disaster	1		X									
		Healthcare organization recovery assistance and participation	3		X	X								X
Function 2: Assist healthcare organizations to implement Continuity of Operations (COOP)	TRUE	COOP planning assistance for healthcare organizations	1		X									
		Healthcare organization COOP implementation assistance	1		X									
		Healthcare organization recovery assistance	1		X									



APPENDIX C

Function	At least one measure maps to some aspect of this function	Resource Element	Number of measures that map to the resource elements	HPP Measures							HPP-PHEP Measures	
				1.1	2.1	3.1	5.1	6.1	10.1	14.1	15.1	6.1
Emergency Operations Coordination												
Function 1: Healthcare organization multi-agency representation and coordination with emergency operations	TRUE	Healthcare organization multi-agency coordination during response	1			X						
		Healthcare organization and emergency operations decision coordination	1			X						
Function 2: Assess and notify stakeholders of healthcare delivery status	TRUE	Healthcare organization resource needs assessment	0									
		Incident information sharing	1			X						
		Community notification of healthcare delivery status	0									
Function 3: Support healthcare response efforts through coordination of resources	TRUE	Identify available healthcare resources	0									
		Resource management implementation	0									
		Public health resource support to healthcare organizations	1			X						
		Managing and resupplying resource caches	0									
		Inventory management system	0									
Function 4: Demobilize and evaluate healthcare operations	TRUE	Resource demobilization	0									
		Evaluation and continuous program improvement	1			X						
		Evaluation training	1			X						
Fatality Management												
Function 1: Coordinate surges of deaths and human remains at healthcare organizations with community fatality management operations	TRUE	Anticipate storage needs for a surge of human remains	0									
		Healthcare organization human remain surge plans	0									
		Mortuary storage equipment and supplies	1			X						



APPENDIX C

Function	At least one measure maps to some aspect of this function	Resource Element	Number of measures that map to the resource elements	HPP Measures										HPP-PHEP Measures			
				1.1	2.1	3.1	5.1	6.1	10.1	14.1	15.1	6.1	15.1				
Function 2: Coordinate surges of concerned citizens with community agencies responsible for family assistance	TRUE	Procedures for a surge of concerned citizens	1				X										
Function 3: Mental or behavioral support at the healthcare organization level	TRUE	Mental/behavior health support	1				X										
Information Sharing																	
Function 1: Provide healthcare situational awareness that contributes to the incident common operating picture	TRUE	Healthcare information sharing plans	10	X	X	X	X	X	X	X	X	X	X	X	X	X	
		Healthcare essential elements of information	2					X							X		
		Healthcare incident information validation	0														
		Healthcare information sharing with the public	0														
		Healthcare information systems	2					X	X								
		Bed tracking	0														
		Bed tracking system	0														
		Bed tracking system training	0														
		Patient tracking	0														
		Patient tracking system	0														
Patient record tracking	0																
Function 2: Develop, refine, and sustain redundant, interoperable communication systems	TRUE	Interoperable communications plans	1					X									
		Interoperable communication system	0														
		Communication training	0														

Function	At least one measure maps to some aspect of this function	Resource Element	Number of measures that map to the resource elements	HPP Measures							HPP-PHEP Measures	
				1.1	2.1	3.1	5.1	6.1	10.1	14.1	15.1	6.1
Medical Surge												
Function 1: The Healthcare Coalition assists with the coordination of the healthcare organization response during incidents that require medical surge	TRUE	Healthcare Coalition preparedness activities	1							X		
		Multi-agency coordination during response	1							X		
Function 2: Coordinate integrated healthcare surge operations with pre-hospital Emergency Medical Services (EMS) operations	TRUE	Healthcare organization coordination with EMS during response	0									
		Coordinated disaster protocols for triage, transport, documentation, CBRNE	1							X		
		Training on local EMS disaster triage methodologies	0									
		Coordinated CBRNE training	0									
Function 3: Assist healthcare organizations with surge capacity and capability	TRUE	Medical surge planning	1							X		
		Medical surge emergency operations coordination	1							X		
		Assist healthcare organizations maximize surge capacity	1								X	
		Medical surge information sharing	1								X	
		Healthcare organization patient transport assistance	1								X	
		Medical surge considerations for at-risk individuals and those with special medical needs	0									
		Specialty equipment to increase medical surge capacity and capability	1								X	



APPENDIX C

Function	At least one measure maps to some aspect of this function	Resource Element	Number of measures that map to the resource elements	HPP Measures							HPP-PHEP Measures		
				1.1	2.1	3.1	5.1	6.1	10.1	14.1	15.1	6.1	15.1
		Special training to maximize medical surge competency	0										
		Mobile medical assets for surge operations	0										
		Mobile Medical Assets	0										
		Decontamination assistance to healthcare organizations	0										
		Decontamination assets	0										
		Decontamination training	0										
		Mental or behavior health support	0										
Function 4: Develop Crisis Standards of Care guidance	TRUE	State crisis standards of care guidance	1						X				
		Indicators for crisis standards of care	1						X				
		Legal protections for healthcare practitioners and institutions	1						X				
		Provide guidance for crisis standards of care implementation processes	1						X				
		Provide guidance for the management of scarce resources	1						X				
		Crisis standards of care training	1						X				
Function 5: Provide assistance to healthcare organizations regarding evacuation and shelter in place operations	TRUE	Healthcare organization evacuation and shelter-in-place plans	0										
		Healthcare organization preparedness to receive evacuation surge	1						X				
		Transportation options for evacuation	1						X				
		Specialized equipment needed to evacuate patients	1						X				



APPENDIX C

Function	At least one measure maps to some aspect of this function	Resource Element	Number of measures that map to the resource elements	HPP Measures							HPP-PHEP Measures	
				1.1	2.1	3.1	5.1	6.1	10.1	14.1	15.1	6.1
Responder Safety and Health												
Function 1: Assist healthcare organizations with additional pharmaceutical protection for healthcare workers	TRUE	Pharmaceutical needs assessment	1								X	
		Pharmaceutical cache storage, rotation, replacement, and distribution	1								X	
		Medical Countermeasure dispensing	1								X	
		Pharmaceutical cache protection	1								X	
		Pharmaceutical cache training	1								X	
Function 2: Provide assistance to healthcare organizations with access to additional Personal Protective Equipment (PPE) for healthcare workers during response	TRUE	Personal protective equipment needs assessment	1								X	
		Personal protective equipment caches	1								X	
		Personal protective equipment supply and dispensing	1								X	
		Personal Protective Equipment for healthcare workers	1								X	
		Personal protective equipment training	1								X	
Volunteer Management												
Function 1: Participate with volunteer planning processes to determine the need for volunteers in healthcare organizations	TRUE	Volunteer needs assessment for healthcare organizations response	2								X	X
		Collect, assemble, maintain and utilize volunteer information	1								X	
		Electronic volunteer registration system	2								X	X



APPENDIX C

Function	At least one measure maps to some aspect of this function	Resource Element	Number of measures that map to the resource elements	HPP Measures									HPP-PHEP Measures	
				1.1	2.1	3.1	5.1	6.1	10.1	14.1	15.1	6.1	15.1	
Function 2: Volunteer notification for healthcare response needs	TRUE	Process to contact registered volunteers	0											
		Process to confirm credentials of responding volunteers	1										X	
		Volunteer request process	1											X
Function 3: Organization and assignment of volunteers	TRUE	Volunteer deployment protocols	1											X
		Briefing template for healthcare volunteers	0											
		Volunteer support services	0											
Function 4: Coordinate the demobilization of volunteers	TRUE	Volunteer Release Processes	0											
		Volunteer exit screening protocols	1										X	

Appendix D: Online Data Collection (OLDC) Template — Section 3, Performance Measures

HHS HPP Cooperative Agreement FY12 Progress Report

Section 3: Performance Measures

Capability 1.1 (Form 3.1.1): HPP Healthcare System Preparedness

Performance Measure: Percent of healthcare coalitions (HCCs) that have established formalized agreements and demonstrate their ability to function and execute the capabilities for healthcare preparedness, response, and recovery as defined in Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness

Performance Target: 100% by the end of the project period (Year 1 data will be used to establish baselines)

Please enter the number of coalitions for each scoring group described below:

Scoring for each data element:

- Enter a “1” for this element has been completely implemented consistent with national expectations
- Enter a “2” for this element is partially implemented
- Enter a “3” for there IS a plan to start implementing this element within the next grant year
- Enter a “4” for there is NO plan to implement this element within the next grant year

NOTE: For 3.1.1.5–3.1.1.8, you may also use the following

- Enter a “5” for there was no opportunity to implement this element within this grant year

	1	2	3	4	5
3.1.1.1 Are there formal documents such as: Memoranda of Understanding (MOUs), Mutual Aid Agreements (MAAs), Interagency Agreement (IAAs), articles of incorporation, letters of agreement, contracts, charters, or other supporting formal documents that define:					
3.1.1.1.1 The member organizations of the HCC?					
3.1.1.1.2 Formal agreement to aid coalition members and to share resources and information					
3.1.1.1.3 A process to allow representation of subject matter experts (SMEs) to the HCC?					
3.1.1.1.4 Joint or cooperative activities with non-healthcare constituencies?					
3.1.1.1.5 Formal agreements to prepare to respond as part of the HCC?					
3.1.1.2 Has the HCC established a formal self-governance structure (e.g., By-laws for the board of directors and a charter that is multidisciplinary and representative of all members of the coalition)?					
3.1.1.3 Please estimate the total percentage of the State population covered by each HCC within the State.					
3.1.1.3.1 Coalition 1					
3.1.1.3.2 Coalition 2					
3.1.1.3.3 Coalition 3					
3.1.1.3.4 Coalition 4					
3.1.1.3.5 Coalition 5					
3.1.1.3.6 Coalition 6					



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3.1.1.3.7	Coalition 7					
3.1.1.3.8	Coalition 8					
3.1.1.3.9	Coalition 9					
3.1.1.3.10	Coalition 10					
3.1.1.3.11	Coalition 11					
3.1.1.3.12	Coalition 12					
3.1.1.3.13	Coalition 13					
3.1.1.3.14	Coalition 14					
3.1.1.3.15	Coalition 15					
3.1.1.3.16	Coalition 16					
3.1.1.3.17	Coalition 17					
3.1.1.3.18	Coalition 18					
3.1.1.3.19	Coalition 19					
3.1.1.3.20	Coalition 20					
3.1.1.3.21	Coalition 21					
3.1.1.3.22	Coalition 22					
3.1.1.4	Does the HCC include emergency management and public health as integral partners?					
3.1.1.5	Has the HCC and its members participated in at least one HSEEP-compliant exercise to test State, regional and facility-level healthcare disaster plans considering scenarios identified by a Hazard Vulnerability Assessment (HVA) within the past year					
3.1.1.6	In the past year, did the HCC achieve its established exercise participation goals for its member organizations engagement in exercises or real events to test regional State, regional and facility-level healthcare disaster plan?					
3.1.1.7	In the past year, did the exercises or real events to test regional, State, and facility-level healthcare disaster plans demonstrate the HCC capabilities to function as a coordinated entity?					
3.1.1.8	Has the HCC successfully implemented “lessons learned” and corrective actions from an exercise or event within the past year?					

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Section 3: Performance Measures
Capability 2.1 (Form 3.2.1): HPP Healthcare System Recovery

Performance Measure: Percent of healthcare coalitions (HCCs) that have developed processes for short-term recovery of healthcare service delivery and continuity of business operations

Performance Target: 100% by the end of the project period (Year 1 data will be used to establish baselines)

Please enter the number of coalitions for each scoring group described below:

Scoring for each data element:

- Enter a “1” for this element has been completely implemented consistent with national expectations
- Enter a “2” for this element is partially implemented
- Enter a “3” for there IS a plan to start implementing this element within the next grant year
- Enter a “4” for there is NO plan to implement this element within the next grant year

NOTE: For 3.2.1.9–3.2.1.10, you may also use the following

- Enter a “5” for there was no opportunity to implement this element within this grant year

		1	2	3	4	5
3.2.1.1	Has a risk-based regional/jurisdictional Hazard Vulnerability Analysis (HVA) been conducted within the past 3 years that identifies events and incidents that may impact the ability of HCC member hospitals and other healthcare organizations (HCOs) to deliver healthcare?					
3.2.1.1.1	Within the past 3 years?					
3.2.1.1.2	That identifies events and incidents that may impact the ability of an HCC’s hospitals and other healthcare organizations (HCOs) to deliver healthcare?					
3.2.1.1.3	That assessed identified events or incidents as to their potential impacts on the hospital and other HCC members, such as power outages, water outages, road outages and supply chain disruptions?					
3.2.1.1.4	That identified healthcare recovery needs and prioritized them based on those potential impacts?					
3.2.1.2	Does the HCC ensure that its hospitals and other HCOs are integrated in the jurisdiction’s Emergency Operations Plan that is intended to meet prioritized essential health care recovery needs?					
COOP Planning						
3.2.1.3	Has the HCC, its hospitals, and other HCO members implemented AND tested plans and processes for continuing and sustaining operations (e.g., hardening facilities) within the past three years?					
3.2.1.4	Does the HCC coordinate with each of its hospitals and other HCOs to enhance member support in planning for continuity of operations plans?					
3.2.1.5	Has the HCC coordinated with the State and with its HCOs to develop a regional recovery and continuity of operations plan?					



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3.2.1.6	Does the HCC coordinate its hospitals' and other HCOs' use of Electronic Medical Records, and link their use in their continuity of operations plans?					
3.2.1.7	Do HCC hospitals and other HCOs incorporate guidance on messaging to their workforce into their continuity of operations plans?					
3.2.1.8	Can HCC hospitals and other HCOs maintain essential functions (e.g. continue to bill for payment with healthcare insurers) to sustain revenues to operate during and after an emergency?					
3.2.1.9	Has the HCC successfully tested processes for short-term recovery of healthcare service delivery and continuity of business operations in an exercise or event?					
3.2.1.9.1	Within the past year?					
3.2.1.10	Has the HCC successfully implemented lessons learned and corrective actions from this exercise or event?					

HHS HPP Cooperative Agreement FY12 Progress Report
Section 3: Performance Measures
Capability 3.1 (Form 3.3.1): HPP Emergency Operations Coordination

Performance Measure: Percent of healthcare coalitions (HCCs) that use an integrated Incident Command Structure (ICS) to coordinate operations and sharing of critical resources among HCC organizations (including emergency management and public health) during disasters

Performance Target: 100% by the end of the project period (Year 1 data will be used to establish baselines)

Please enter the number of coalitions for each scoring group described below:

Scoring for each data element:

- Enter a “1” for this element has been completely implemented consistent with national expectations
- Enter a “2” for this element is partially implemented
- Enter a “3” for there IS a plan to start implementing this element within the next grant year
- Enter a “4” for there is NO plan to implement this element within the next grant year

NOTE: For 3.3.1.3–3.3.1.5, you may also use the following

- Enter a “5” for there was no opportunity to implement this element within this grant year

		1	2	3	4	5
3.3.1.1	Has the HCC and its members successfully exercised protocols for notifying non-partner support agencies to activate mutual aid agreements for resource support within the last year?					
3.3.1.2	Has the HCC planned with partner hospitals and other HCOs to identify each hospital and other HCO’s maximum patient capacity to establish its baseline as a coalition?					
3.3.1.3	Has the HCC coordinated healthcare response operations with appropriate patient transport operations within the community, in an exercise or event, within the past year?					
3.3.1.4	In the past year, which of the following functions were successfully demonstrated by the HCC’s hospitals and other HCOs in the exercise or event in which the HCC participated?					
3.3.1.4.1	Triage					
3.3.1.4.2	Treatment					
3.3.1.4.3	Transport					
3.3.1.4.4	Tracking of patients					
3.3.1.4.5	Documentation of care					
3.3.1.4.6	Off-loading					
3.3.1.5	Has the HCC successfully exercised notification protocols for its hospitals and other HCOs within the last year?					
3.3.1.6	Are HCC members integrated into an HCC incident command structure such that the members are included in HCC Regional Plans?					

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Section 3: Performance Measures
Capability 5.1 (Form 3.5.1): HPP Fatality Management

Performance Measure: Percent of healthcare coalitions (HCCs) that have systems and processes in place to manage mass fatalities consistent with their defined roles and responsibilities.

Performance Target: 100% by the end of the project period (Year 1 data will be used to establish baselines)

Scoring for each data element:

- Enter a “1” for this element has been completely implemented consistent with national expectations
- Enter a “2” for this element is partially implemented
- Enter a “3” for there IS a plan to start implementing this element within the next grant year
- Enter a “4” for there is NO plan to implement this element within the next grant year

NOTE: For 3.5.1.4–3.5.1.5, you may also use the following

- Enter a “5” for there was no opportunity to implement this element within this grant year

		1	2	3	4	5
3.5.1.1	Has the HCC identified the roles and responsibilities of member organizations and other key partners for managing mass fatalities, including but not limited to the following:					
3.5.1.1.1	Identifying response actions of HCC members, including local health departments, local emergency management, hospitals, other HCOs, and other key partners (e.g., funeral directors, coroners, medical examiners)					
3.5.1.1.2	Identifying who is responsible for each of the Fatality Management functions					
3.5.1.1.3	Identifying legal or regulatory authority of member organizations and key partners that govern fatality management in the local jurisdiction, including any necessary waivers (e.g. determining cause of death, identification and storage of remains, family notification, burial permits and vital records, etc.)					
3.5.1.2	Has the HCC established systems and processes to manage mass fatalities consistent with its defined roles and responsibilities, including but not limited to the following:					
3.5.1.2.1	Ensuring that systems and processes are aligned with the local jurisdictional EOP or fatality management plan					
3.5.1.2.2	Identifying critical pathways or trigger points for response actions					
3.5.1.2.3	Providing training on fatality management coordination					
3.5.1.2.4	Establishing communication systems among members and key partners, including mental or behavioral health professionals					
3.5.1.2.5	Developing concepts of operations and standard operating procedures					



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3.5.1.3	Has the HCC established systems and processes to manage a surge of concerned citizens requesting information about missing family members, including how to contact the responsible agency for family support, and protocols to ensure its HCOs can connect with family assistance and/or family reception centers?					
3.5.1.4	Has the HCC successfully tested its systems and processes for managing mass fatalities during an exercise or event?					
3.5.1.4.1	Within the past year?					
3.5.1.5	Has the HCC successfully implemented lessons learned and corrective action from this exercise or event within the past year?					

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Section 3: Performance Measures
Capability 6.1 (Form 3.6.1): HPP Information Sharing

Performance Measure: Percent of healthcare coalitions (HCCs) that can continuously monitor Essential Elements of Information (EEl)s and demonstrate the ability to electronically send data to and receive data from coalition members to inform a Common Operating Picture

Performance Target: 100% by the end of the project period (Year 1 data will be used to establish baselines)

Please enter the number of coalitions for each scoring group described below:

Scoring for each data element:

- Enter a “1” for this element has been completely implemented consistent with national expectations
- Enter a “2” for this element is partially implemented
- Enter a “3” for there IS a plan to start implementing this element within the next grant year
- Enter a “4” for there is NO plan to implement this element within the next grant year

NOTE: For 3.6.1.5–3.6.1.7, you may also use the following

- Enter a “5” for there was no opportunity to implement this element within this grant year

	1	2	3	4	5
3.6.1.1 Has the HCC identified essential elements of information (EEl)s that the HCC members must report for specific types of events to inform the common operating procedure? Examples of EEl data include: <ul style="list-style-type: none"> ▪ Facility operating status ▪ Facility structural integrity ▪ Status of evacuations/shelter in place operations ▪ Critical medical services (e.g., critical care, trauma) ▪ Critical service status (e.g., electric, water, sanitation, heating, ventilation, air conditioning) ▪ Critical healthcare delivery status (e.g., surge status, bed status, deaths, medical and pharmaceutical supply and medical equipment) ▪ Staffing status ▪ Emergency Medical Services status involving patient transport, tracking and availability ▪ Electronic patient tracking ▪ Electronic bed tracking 					
3.6.1.2 Has the HCC defined data usage and access policies for the EEl data?					
3.6.1.3 Has the HCC have redundant systems and processes in place to electronically send and receive the EEl data?					
3.6.1.4 Can the HCC share basic epidemiological and/or clinical data with relevant local health departments?					
3.6.1.5 Are the HCC members able to report the identified EEl)s electronically within the timeframe requested as evidenced by performance during exercises or events?					



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3.6.1.6 Is the HCC able to receive and quickly process the EEI data to provide timely, relevant, and actionable healthcare information to the common operating picture as evidenced by performance during exercises or events?					
3.6.1.7 Have the HCC members successfully implemented lessons learned and corrective action from this exercise or event within the past year?					



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Section 3: Performance Measures

Capability 6.1 (Form 3.6.2): HPP-PHEP Information Sharing

Joint Performance Measure: Percent of local partners that reported requested Essential Elements of Information (EEI) to health and medical lead within the requested timeframe.

Joint Performance Target: 100% by the end of the project period (Year 1 data will be used to establish baselines)

		Incident/ Planned Event/ Exercise 1	Incident/ Planned Event/ Exercise 2
3.6.2.1	On each incident, planned event, or exercise reported for demonstration of the Information Sharing Capability, please answer the following information:		
3.6.2.2	This incident, planned event, or exercise utilized or demonstrated one or more function(s) within the		
3.6.2.3	The number of local partners that received a request for EEI (denominator)		
3.6.2.4	The number of local partners that reported requested EEI to the health and medical lead within the requested timeframe (numerator)		
3.6.2.5	The request for EEI occurred during a (select one):		
3.6.2.6	The type of incident, exercise, or planned event upon which the request for EEI was based (check all that apply):		
3.6.2.7	Other Specified		
3.6.2.8	The name of the incident/planned event/exercise		
3.6.2.9	The date of the incident/planned event/exercise		
3.6.2.10	The number of each type of local partner that responded to the request	3.6.2.11 Healthcare Organizations	
		3.6.2.12 Healthcare Coalitions	
		3.6.2.13 Local Health Departments	
		3.6.2.14 Other Specified	
		3.6.2.15 Other numeric	
3.6.2.16	The requesting entity (e.g., health and medical lead at the State, sub-state regional, or local level).		
3.6.2.17	Other requesting entity specified		
3.6.2.18	The type(s) of EEI requested. (Select all that apply)		
3.6.2.19	Other EEI Specified		
3.6.2.20	The type of IT or other communication system used to request EEI from local partners		
3.6.2.21	The type of IT or other communication system used by local partners to report requested EEI		



3.6.2.22 Barriers/challenges to submitting requested EEI within the requested timeframe (please describe types of local partners experiencing challenges and types of EEI not submitted within requested timeframe).

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Section 3: Performance Measures
Capability 10.1 (Form 3.10.1): HPP Medical Surge

Performance Measure: Percent of healthcare coalitions that have a coordinated mechanism established that supports their members’ ability both to deliver appropriate levels of care to all patients (including pre-existing patients [both inpatient and outpatient], non-disaster-related patients, and disaster-specific patients), as well as to provide no less than 20% bed availability of staffed members’ beds, within 4 hours of a disaster

Performance Target: 100% by the end of the project period (Year 1 data will be used to establish baselines)

Please enter the number of coalitions for each scoring group described below:

Scoring for each data element:

- Enter a “1” for this element has been completely implemented consistent with national expectations
- Enter a “2” for this element is partially implemented
- Enter a “3” for there IS a plan to start implementing this element within the next grant year
- Enter a “4” for there is NO plan to implement this element within the next grant year

NOTE: For 3.10.1.2–3.10.1.5, you may also use the following

- Enter a “5” for there was no opportunity to implement this element within this grant year

	1	2	3	4	5
3.10.1.1 Do the surge plans of the HCC hospitals and other HCC members include written clinical practice guidelines for Crisis Standards of Care for use in an incident, including triggers that delineate shifts in the continuum of care from conventional to crisis standards of care?					
3.10.1.2 Has the HCC successfully tested its coordinated mechanism to both deliver appropriate levels of care to all patients, as well as to provide no less than 20% immediate availability of staffed members’ beds, within 4 hours of a disaster?					
3.10.1.3 Has the HCC successfully implemented lessons learned and corrective action from this exercise or event within the past year?					
3.10.1.4 Has the HCC demonstrated the ability to communicate regional healthcare surge status in an exercise or event within the past year?					
3.10.1.5 Has the HCC demonstrated the ability to communicate regional healthcare surge status in an exercise or event within the past year?					
3.10.1.6 Does the HCC have the ability to expand its coalition-wide surge capacity according to the scope and magnitude of the incident?					
3.10.1.7 Does the HCC have the ability to communicate and coordinate support to its member organizations so that members can perform surge functions and coordinate distribution of resources to support those functions?					

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Section 3: Performance Measures
Capability 14.1 (Form 3.14.1): HPP Responder Safety and Health

Performance Measure: Percent of healthcare coalitions that have systems and processes in place to preserve healthcare system functions and to protect all of the coalition member employees (including healthcare and non-healthcare employees)

Performance Target: 100% by the end of the project period (Year 1 data will be used to establish baselines)

Please enter the number of coalitions for each scoring group described below:

Scoring for each data element:

- Enter a “1” for this element has been completely implemented consistent with national expectations
- Enter a “2” for this element is partially implemented
- Enter a “3” for there IS a plan to start implementing this element within the next grant year
- Enter a “4” for there is NO plan to implement this element within the next grant year

NOTE: For 3.14.1.3–3.14.1.4, you may also use the following

- Enter a “5” for there was no opportunity to implement this element within this grant year

	1	2	3	4	5
3.14.1.1 Has the HCC implemented an occupational safety and health plan to protect employees of the organizations within the HCC and their families, based on a Hazard Vulnerability Analysis (HVA) conducted within the last 3 years?					
3.14.1.2 Do HCC member organizations have access to the elements of an occupational safety and health plan that includes:					
3.14.1.2.1 Pharmaceutical caches					
3.14.1.2.2 PPE					
3.14.1.2.3 Medical countermeasures					
3.14.1.2.4 Risk communications					
3.14.1.2.5 Family member protections and considerations					
3.14.1.2.6 Social distancing protocols					
3.14.1.2.7 Behavioral health					
3.14.1.2.8 Security					
3.14.1.3 Has the HCC successfully tested its systems and processes to preserve healthcare system functions and to enhance support of all HCC member employees (including healthcare and non-healthcare employees) in an exercise or event?					
3.14.1.3.1 Within the past year?					
3.14.1.4 Has the HCC successfully implemented lessons learned and corrective actions from the exercise or event within the past year?					

HHS HPP Cooperative Agreement FY12 Progress Report
Section 3: Performance Measures
Capability 15.1 (Form 3.15.1): HPP Volunteer Management

Performance Measure: Percent of healthcare coalitions (HCCs) that have plans, processes and procedures in place to manage volunteers supporting a public health or medical incident.

Performance Target: 100% by the end of the project period (Year 1 data will be used to establish baselines)

Please enter the number of coalitions for each scoring group described below:

Scoring for each data element:

- Enter a “1” for this element has been completely implemented consistent with national expectations
- Enter a “2” for this element is partially implemented
- Enter a “3” for there IS a plan to start implementing this element within the next grant year
- Enter a “4” for there is NO plan to implement this element within the next grant year

NOTE: For 3.15.1.4–3.15.1.5.5, you may also use the following

- Enter a “5” for there was no opportunity to implement this element within this grant year

	1	2	3	4	5
3.15.1.1 Does the HCC have procedures for identifying the type and quantity of volunteers needed to support healthcare response?					
3.15.1.2 Does the HCC have or have access to an electronic registration system for recording and managing volunteer information that is compliant with the current guidelines of the HHS ESAR-VHP program?					
3.15.1.3 Has the HCC coordinated with the State and HCC members to develop plans, processes and procedures to manage volunteers that address the following areas:					
3.15.1.3.1 Receiving volunteers					
3.15.1.3.2 Determining volunteer affiliation, including procedures for integrating or referring non-registered or spontaneous volunteers					
3.15.1.3.3 Confirming volunteer credentials					
3.15.1.3.4 Assigning roles and responsibilities to volunteers					
3.15.1.3.5 Providing just in time training for volunteers					
3.15.1.3.6 Tracking volunteers					
3.15.1.3.7 Out-processing volunteers					
3.15.1.4 Has the HCC successfully tested its plans, processes and procedures for managing volunteers during an exercise or event within the past year?					
3.15.1.4.1 Within the past year?					
3.15.1.5 Has the HCC successfully implemented lessons learned and corrective action from this exercise or event within the past year?					



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Section 3: Performance Measures

Capability 15.1 (Form 3.15.2): HPP-PHEP Volunteer Management

Joint Performance Measure: Proportion of volunteers deployed to support a public health or medical incident within an appropriate timeframe.

Joint Performance Target: 100% by the end of the project period (Year 1 data will be used to establish baselines)

	Incident/ Planned Event/ Exercise 1	Incident/ Planned Event/ Exercise 2
3.15.2.1	On each incident, planned event, or exercise reported for demonstration of the Volunteer Management Capability, please answer the following information:	
3.15.2.2	This incident, planned event, or exercise utilized or demonstrated one or more function(s) within the:	
3.15.2.3	The request for volunteers occurred during a (select one):	
3.15.2.4	The type of incident, exercise, or planned event upon which the request for volunteers was based (select all that apply):	
3.15.2.5	Biological hazard or disease or other specified	
3.15.2.6	The name of the incident/planned event/exercise	
3.15.2.7	The date of the incident/planned event/exercise	
3.15.2.8	The date/time when request for volunteers was received by health/medical lead.	
3.15.2.9	The number of volunteers requested to deploy from the originating requestor (denominator)	
3.15.2.10	The entity that made the original request for volunteers (drop-down)	
3.15.2.11	Other entity specified	
3.15.2.12	The date/time when volunteers were requested to arrive at staging area or on scene by health and medical lead	
3.15.2.13	The requested location for the deployment (select one):	
3.15.2.14	Other requested location specified	
3.15.2.15	The number of volunteers who were notified to deploy ("activated")	
3.15.2.16	The date/time when the last volunteer was notified to deploy (i.e., "activated")	
3.15.2.17	The number of volunteers who arrived at staging area/on scene within requested timeframe (numerator)	
3.15.2.18	Number of deployed volunteers registered in ESAR-VHP	
3.15.2.19	Number of deployed volunteers registered in other systems	



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3.15.2.20 Date/time that last volunteer arrived at staging area/on scene within requested timeframe

3.15.2.21 Barriers/challenges to deploying volunteers to support a public health/medical incident within requested timeframe
