2017-2022 HPP Performance Measure Implementation Guidance Training

Frequently Asked Questions (FAQs)

Office of the Assistant Secretary for Preparedness and Response

ASPR
ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

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Introduction

This Frequently Asked Questions (FAQ) document contains a compiled list of questions and answers from the June 2017 live webinar trainings on the 2017-2022 HPP Performance Measures Implementation Guidance document. Many answers contain additional context from what was discussed during the live sessions. Additionally, there are several instances where the answers contained in this FAQ are clarifications and corrections to what was stated during the webinar – in these instances, the information contained in this FAQ document (rather than the webinar) is correct and should be used as guidance – these answers are marked with an exclamation point icon.

General Questions

Where can I access the 2017-2022 Hospital Preparedness Program (HPP) Performance Measure Implementation Guidance?

You can access the 2017-2022 HPP Performance Measure Implementation Guidance on the www.phe.gov website through either the HPP guidance, reports, and research webpage or the Science, Healthcare, Preparedness, Evaluation and Research (SHARPER) performance measures webpage. Alternatively, you can access the document directly from this link 2017-2022 Hospital Preparedness Program Performance Measures Implementation Guidance.

What does SHARPER stand for?

SHARPER stands for Science, Healthcare, Preparedness, Evaluation and Research. SHARPER is the branch that oversees performance measurement and analysis related to the HPP cooperative agreements.

Where can I find the materials from the Implementation Guidance training webinar?

A recording of the Implementation Guidance training webinar and this Frequently Asked Questions (FAQ) document, which includes all questions asked during the live webinars, are available online in the Performance Measures Toolkit section of the SHARPER Performance Measures webpage on phe.gov. Additionally, you can find a separate webinar recording for the HPP Implementation Guidance Training for Select U.S. Territories and Freely Associated States in the Performance Measures Toolkit section.

Where should I direct questions about the measures or the Implementation Guidance?

Questions related to the measures, the Measures Implementation Guidance, and future data collection can be directed to the SHARPER mailbox at SHARPER@HHS.gov.

Overall Performance Measures and Templates

Will each state put out guidance on dates and forms for Health Care Coalitions (HCCs) to report Performance Measures?

Data is due from the awardee to HPP within 90 days of the end of each budget period. However, ASPR does not control data reporting requirements of health care coalitions (HCCs). Each

state/awardee may establish its own requirements of HCCs, to include, data collection and reporting methods (e.g., specific forms to use) and timing requirements.

How do the Performance Measures align to the new Centers for Medicare & Medicaid Services (CMS) Emergency Preparedness Rule?

The HPP Performance Measures do not directly align to the CMS Emergency Preparedness Rule, as the unit of measure for the HPP Performance Measures is at the awardee or HCC level, whereas, the CMS Emergency Preparedness Rule is at the individual health care providers and suppliers level.

Is there a template for Memorandums of Understanding (MOUs) and/or letters of agreement that you recommend?

We do not have any one specific template for MOUs and/or letters of agreement. However, ASPR Technical Resources, Assistance Center, and Information Exchange (TRACIE) has a number of documents available already, including promising practice documents around governance, MOUs, and other templates. There will be many more templates and examples added to ASPR TRACIE Healthcare Coalition Development and Organization topic collection, especially in the form of Preparedness Plans, Response Plans, and gap analyses over the coming weeks into this summer. We recommend that you look at those Preparedness Plan templates when they are posted, as well as the promising practices that are already on ASPR TRACIE, to see which work best for you and the way your coalition is structured. You are able to take those resources and make the necessary changes so that they fit your needs.

Is it expected that the Performance Measures are reported every year if not noted in the operational intent?

Yes. All Performance Measures are expected to be reported annually, 90 days after the end of each budget period.

Is there an HCC governance template that HCCs should be following?

Over the last few years, we solicited many of your planning documents, bylaws, and information directly from you. We are compiling and will be posting promising practices on ASPR TRACIE. There are already some examples of governance documents and bylaws, both on the NACCHO website from a webinar we hosted with them about three years ago, as well as on ASPR TRACIE. We will continue to post additional documents through August 2017.

The purpose of posting these promising practice documents is to give you an idea of where to start, and for you to pull the elements that work for your HCC from various documents. It is unlikely that a single document will meet all of your needs. We understand that there is not one single structure that will work for every HCC; therefore, we do not ask you to use one single standard document.

HCC Membership and Funding

How are core members of the HCC defined?

As listed in the HPP Funding Opportunity Announcement (FOA), the core members are acute care hospitals, public health agencies, emergency management organizations, and emergency

medical services. To be clear, the requirement is that a minimum of two acute care hospitals are part of each coalition. "Acute care" has nothing to do with the size of the facility or the number of beds of the facility. "Acute care" relates to the types of services provided. As long as a hospital provides acute in-patient or surgical care, then critical access hospitals, or other various small hospitals, can be considered an acute care facility.

Given that awardees may fund an HCC coordinator who provides services or resources to all HCCs, how should HCCs accurately report funding data to HPP?

For most HPP-funded positions at the awardee level (e.g., health department employees), 100 percent of the position is not directly providing services and resources to HCCs. However, if this individual is really coordinating the HCCs—not just interfacing with them—then it would be appropriate to split their salary—or a portion of their salary—among those HCCs they are coordinating. The awardee should communicate this shared cost with the appropriate HCCs and the funding should be visible in both the awardee and HCCs' budget. The awardee should coordinate with its HCCs to ensure that this cost is appropriately reflected in the HCCs reported funding data.

Data collection, as it relates to HPP, has always depended on a process whereby data is collected and aggregated by the awardee and reported to HPP. While the process for data collection may vary by jurisdiction, the expectation is that the awardee will collect, validate, and report data for each HCC within its jurisdiction unless otherwise directed. This will give awardees the opportunity to confirm that this type of shared resource is captured accurately.

Will the awardee be held accountable if an awardee provides all necessary contract documents to subawardees on time, but the subawardees fail to meet contract timeline requirements resulting in the contract being executed after 90 days?

Before funds are withheld, there will be additional follow up, and a review will occur on a case-by-case basis. In addition, prior to withholding funds, HPP will provide technical assistance and work with the awardee to determine methods to correct the deficiency.

Preparedness and Response Plans

When are the Preparedness Plans and Response Plans due?

HCCs are required to complete a draft Preparedness Plan by April 1, 2018. Field project officers (FPOs) or the awardee may request the plan at any time in order to assess the status of the plan(s), help you finalize the plan(s), and/or provide technical assistance.

Correction from the Live Webinar(s): An Approved Preparedness Plan is due at the end of Budget Period **1**. Furthermore, awardees **are** required to submit their HCCs' final Preparedness Plan with the Budget Period 1 Annual Progress Report.

As an approved Response Plan is not required until the end of Budget Period 2, will awardees and HCCs need to report data in Budget Period 1 regarding the Response Plan?

Yes. Reporting is required on this and all performance measures in every Budget Period, including Budget Period 1. Reporting in Budget Period 1 will provide a gauge of progress and allow HPP to provide more targeted technical assistance. However, the FOA requirement for the approved Response Plan does not need to be met until the end of Budget Period 2.

In Performance Measure #4, HCC's are required to gather input from all members in the Preparedness Plan. If we are planning to have a core cross-section of partners participate in drafting the plan (e.g. HCC Advisory Board and Education Committee), will that suffice?

One hundred percent (100%) of core member organizations (as defined in Appendix 3 of the Implementation Guidance) are required to approve the complete Preparedness Plan by the end of the first budget period, which ends in June 30, 2018. There is flexibility in terms of how approval can be documented (e.g., through signatures, emails, survey), but approval must be documented.

Additionally, one hundred percent (100%) of all members must be provided the opportunity to provide input into the development of the Preparedness Plan. How you coordinate the distribution and feedback process is up to you.

If all member facilities are required to review and provide input, can this be done through an online survey or participant feedback forms?

Yes. There is flexibility in terms of the distribution, feedback, and approval process (e.g., through signatures, emails, survey); however, approval must be documented.

Are signatures necessary and required for approved plans? We have made other ways to document approval but tried to eliminate signatures due to facility legal restrictions.

As long as there is documentation that there is engagement and approval, that is sufficient. Therefore, emails indicating concurrence with the plan attached when submitted to awardee (and then to HPP) will suffice.

Do we have to send the draft plan anywhere on April 1?

Awardees are required to ensure that all HCCs have a draft Preparedness Plan by April 1, 2018. Field Project Officers (FPOs) or the awardee may request the plan at any time in order to assess the status of the plan(s), help you finalize the plan(s), and/or provide technical assistance.

Correction from the Live Webinar(s): An Approved Preparedness Plan is due at the end of Budget Period **1**. Furthermore, awardees **are** required to submit their HCCs' final Preparedness Plan with the Budget Period 1 Annual Progress Report.

Drills and Exercises

Does every HCC member need to participate in the semiannual Redundant Communications Drill (RCD)?

All HCC members are expected to respond during the semiannual RCD; however, there is no target currently established. SHARPER will establish a baseline from data collected in the first budget period, which will then be used to set targets and goals for subsequent budget periods.

Having redundant communication systems improves the likelihood that all HCC members are able to coordinate response activities during an emergency. HCCs should test their redundant communication systems using the drill prescribed in the FOA (testing at least one primary and one backup communication system) and take corrective action when systems fail.

Communications systems—even when functional—have limited value if they are not used by HCC members.

Where can I find more information about the Coalition Surge Test (CST)?

The Coalition Surge Test (CST) is required to be completed annually for all HCCs except those Select U.S. Territories and Freely Associated States. The CST has two phases and takes a total of 4 hours to complete. The CST is designed to help health care coalitions (HCCs) identify gaps in their surge planning through a low- to no-notice exercise. The exercise's foundation comes from a real-world health care system disaster challenge—the evacuation of a hospital or other patient care facility. The CST tests a coalition's ability to work in a coordinated way to find appropriate destinations for patients using a simulated evacuation of at least 20 percent of a coalition's staffed acute-care bed capacity.

The CST is designed to require very little preparation and planning to conduct. Phase 1 consists of the tabletop portion and facilitated discussion. The tabletop portion, where you identify beds, calculate the percentage of beds and track time, is only 90 minutes of the total 4 hours. The facilitated discussion with coalition members should be conducted on the same day as the tabletop exercise. Phase 2 of the CST is the after-action review with executives and is only about 30-45 minutes. The after-action review can be scheduled for a later date/time as long as it is completed within 30 days of Phase 1.

Health Care Coalition Surge Test (CST) links:

- Information about the CST on the www.phe.gov website
- CST manual
- CST webinar
- CST webinar Q&A

What is the threshold for real-world events? Could a real-world emergency constitute a Mass Casualty Incident (MCI), community surge/patient transfer area zone management occurring, or an extremely high census at a hospital?

In order for data from a real-world event to be used as Performance Measures, the real-world event must have resulted in the evacuation of at least 20% of the coalition's total staffed acute care beds (this number should be identified during development of the HCC's preparedness plan). Additionally, the data collected from the real-world event must be complete/sufficient enough to respond to each Performance Measure question. Performance Measures must still be reported regardless of whether you use data from the CST or a qualifying real-world event.

Who must be included in the exercise? Is there a specific number of persons? Could it be just nursing or would we need to pull a physician away to participate? Others?

More information about the CST and the required players can be found in the CST manual. Below you will find Table 1 from the CST manual for your reference.

Players	Peer Assessors
• Minimal complement of command staff at each evacuating facility • One senior staff member at each facility receiving simulated patients • EMS/patient transport staff	• A LEAD assessor in the regional coordination center or other appropriate location • An EVAC assessor at each evacuating facility • A Trusted Insider who serves as an internal point of contact for the coalition

Who activates the CST exercise (Regional- (Fed), State- or HCC-level)?

Once the HCC decides to run the exercise, a trusted insider (i.e., a member of the assessed HCC who agrees to assist in planning) will recruit assessors and notify the HCC members that the CST will take place within a two week window, but will not provide the date or facilities identified for 'evacuation'. The trusted insider activates the CST exercise with a 60-minute advance warning before the exercise begins, and at this time, the assessment team calls the evacuating patient-care facilities to inform them that they need to stand up their hospital command centers. The CST does not require patient movement. Please refer to the CST manual for more information.

Is there an expected frequency of exercises by an individual hospital?

The CST is expected to be conducted annually, and all HCC core members, including hospitals, at a minimum are expected to participate each time. As stated in Performance Measure 14, *"participation of HCC members is crucial to truly test preparedness and response capabilities thus this indicator is intended to gauge the extent to which HCC core member organizations are engaged in coalition exercises."*

Additionally, in the definitions section of Performance Measure 14 it states, *"a member organization is considered to be participating if they are physically or remotely connected to the conduct of the CST or real-world evacuation in real time. A core member organization should be marked as 'not participating' if it did not participate."*

Is the "Assessment Team" for the exercise surge test comprised of peers?

Yes. The CST includes a user-friendly peer assessment low- to no-notice exercise that helps HCCs identify gaps in their surge planning. The CST is designed for use by peer assessors selected by the coalition—anyone with enough coalition expertise to provide meaningful feedback, but with enough distance to provide an objective assessment, may make a suitable peer assessor (i.e., neighboring HCCs). Please refer to the CST manual for more information.

When calculating 20 percent of beds to evacuate during the CST, are you looking for total number of beds just associated with HCC member hospitals or all hospitals in the region?

The 20 percent of beds is in reference to 20 percent of the total HCC members' staffed acute care beds (this number should be identified during development of the Preparedness Plan). HPP is not asking you to evacuate beds at hospitals that are not coalition members. To clarify, the CST is a tabletop exercise, and you are not required to move patients.

Do we count licensed beds or staffed beds?

Clarification from the Live Webinar(s): The CST tests a coalition's ability to work in a coordinated way to find appropriate destinations for patients using a simulated evacuation of at least 20 percent of a coalition's **staffed** acute-care bed capacity.

Can you define what is meant by evacuation? Does evacuation mean the movement of patients because you're evacuating a facility because of a facility problem or does evacuation mean the transfer of patients to create bed space for a surge of incoming patients?

This is outlined in the CST materials, but it includes both components. Facilities identified to evacuate will need to look at their bed census to determine the types of beds needed at other facilities for the evacuating patients. Similarly, other facilities will need to identify their bed availability to accept patients from the evacuating facilities. However, there is no actual movement of patients. You are using the real information about the facilities' bed census and patients at your facilities on that day to determine patient acuity, and based on that, who should be moved to a certain location depending on availability of the right types of beds and how to transport them there.

Does the CST need to be performed each year?

Yes. The CST must be performed every budget period. Performance data based on the CST is required annually.

Is ASPR going to provide guidance in getting a funded position for the HCCs to be able to meet all the requirements and conduct an annual CST? In most cases, many members of an HCC have a job where preparedness is a major component.

No, HPP recognizes that with current funding and HCC structure, many people must play multiple roles to ensure our nation's preparedness, even if it is not their sole job.

For clarification, the CST takes a total of 4 hours to complete and is designed to require very little preparation and planning to conduct. Phase 1 consists of the tabletop portion and facilitated discussion. The tabletop portion, where you identify beds, calculate the percentage of beds and track time, is only 90 minutes of the total 4 hours. The facilitated discussion with coalition members should be conducted on the same day as the tabletop exercise. Phase 2 of the CST is the after-action review with executives and is only about 30-45 minutes. The after-action review can be scheduled for a later date/time as long as it is completed within 30 days of Phase 1.

The goal is to be able to find placement for the "evacuated" patients that make up 20 percent of the HCC's beds in those 90 minutes; however, based on your facility size and overall preparedness, we understand that this may not be achieved, especially in the first year.

What is the purpose and intent in debriefing the CST with hospital executives?

An executive is defined in the Implementation Guidance as a decision-maker for his/her respective organization and should have decision-making power to include, but not limited to, allocating or reallocating resources, changing staffing roles and responsibilities, and modifying business processes in his/her organization.

Participation of executives from HCC member organizations demonstrates an HCC's ability to perform its role as a convener. Executive-level participation in the after action review phase of the CST increases the likelihood that HCC member organizations can act on lessons learned, improving preparedness and response capabilities for their communities. This provides insight into the extent to which HCC core member organizations' executives are engaged in the lessons learned event of the required surge exercise to enable systematic learning. Note that the After Action Review phase of the CST only needs to occur within 30 days of completing phase one of the CST, but preferably as soon as possible.

What level of executive participation are you looking for?

An executive is defined in the Implementation Guidance as a decision-maker for his/her respective organization and should have decision-making power to include, but not limited to, allocating or reallocating resources, changing staffing roles and responsibilities, and modifying business processes in his/her organization.

Page 36 of the Implementation Guidance has a list of common executive title examples, but this list is not exhaustive. Some titles include, Chief Medical Officer, Chief Nursing Officer, Chief Operations Officer, Public Health Commissioner, Public Health Director, EM Directory, and EMS Director. Ideally, this will mean engaging C-Suite level executives because their participation in the after action review phase of the CST increases the likelihood that HCC member organizations can act on lessons learned, improving preparedness and response capabilities for their communities. This is why Phase 2, the after-action review, can be scheduled at a different time than the exercise; we realize it is hard to coordinate everyone's calendars. If the after action review is scheduled in advance of the CST taking place, it may or may not occur on the same day as the CST. This phase should be conducted as soon as possible after Phase 1 and ideally the same day, but must occur within 30 days of Phase 1.

We only have one hospital within our HCC that has 20 percent or more of the beds within the coalition. Do we need to evacuate two or more acute care hospitals for each CST or can we focus on evacuating one hospital?

It's a percentage. If your HCC has four hospitals that combined have a total of 100 acute care beds, you have to evacuate 20 beds total. Whether that is one entire hospital, a portion of a hospital, or multiple hospitals – it has to make up 20 percent of the total HCC's staffed acute care beds.

For the CST, can you only evacuate from three or fewer hospitals?

The CST tool is currently being updated to allow for up to 10 facilities to be evacuated and will be posted online with the other CST materials as soon as it is available. If you need to evacuate from more than 10 facilities, contact SHARPER at SHARPER@HHS.GOV for support in advance.

Hospital Surge Test

Where can I find more information about the Hospital Surge Test (HST)?

The HST is required to be completed annually for Select U.S. Territories and Freely Associated States, which are American Samoa, the Commonwealth of the Northern Mariana Islands, U.S. Virgin Islands, the Federated States of Micronesia, the Republic of Palau, and the Republic of the

Marshall Islands. The HST takes between 90 and 120 minutes to complete. The HST is a user-friendly peer assessment designed to identify gaps in a hospital's preparedness and help assess its ability to respond to a mass casualty event. The HST includes a low- to no-notice exercise and incorporates the real-life considerations of healthcare delivery in acute care settings.

The HST is intended for use by hospital emergency managers, hospital administrators, and clinical staff to assess and improve their hospital's surge plans. The HST has two components, one for triaging patients in the emergency department (ED) and another for the hospital incident command center. Additionally, an after-action review is required.

Though the Hospital Surge Test (HST) is not required for most HCCs, except Select U.S. Territories and Freely Associated States, we have seen a few facilities use the HST to meet some, but not all, of the conditions of participation of the CMS Emergency Preparedness Rule. The HST is available on the www.phe.gov website for anyone to use even though it is not required for most coalitions.

Hospital Surge Tool (HST) links:

- More information about the HST on the www.phe.gov website
- HST manual

Data Collection

What will the data collection system be for Budget Period 1 for the 2017-2022 project period?

HPP and PHEP are in the very early stages of the development of a new data collection IT system. This new data collection system will replace the legacy PERFORMS system. We are considering the positive and negative attributes of PERFORMS while we develop this improved data collection system. HPP will communicate information and guidance regarding data reporting changes for each budget period until the permanent system is in place.

Will existing data in PERFORMS, to include Budget Period 5 HCC member lists, transfer to the new and/or interim data collection system?

If the interim system is PERFORMs, then there is a chance that the data will carry over; otherwise, it is unlikely that it will transfer. Again, HPP will communicate and release appropriate guidance for all data reporting changes for each relevant budget period.

Who is responsible for validating HCC data?

HPP directly funds awardees. These awardees are responsible for validating data when the HCC or hospital is the data entity. The data entity refers to the organization responsible for providing the data. If required, a representative from HPP or the SHARPER Branch will follow-up with an awardee to ensure a data point is valid.

What is the timeline for HPP to establish baselines, targets, and benchmarks?

Awardees must report on all required performance measures within 90 days after the close of the budget period. Budget Period 1 for the 2017-2022 project period begins on July 1, 2017 and ends on June 30, 2018. Therefore, awardees must report data for Budget Period 1 to HPP by

September 30, 2018. Following awardee submission of data, there is time spent on data validation, data assurance, and initial data analysis.

SHARPER will use the data reported for Budget Period 1 to establish a baseline for awardees and HCCs for those Performance Measures indicated in the Goal or Target section. SHARPER will then use the baseline data, benchmarks, and/or program requirements to set targets and goals.

This process may take between three to six months. HPP and SHARPER will communicate relevant performance measure targets and goals as soon as this information is available.

Achievement of the target in future budget periods will be determined by comparing awardees and HCCs against previously reported data and their peers or a subset of their peers, such as those sharing similar demographics, resources, risk profiles, among other characteristics.

Certain Performance Measures require the data entity to reference operational documents, such as governance documents or response plans. Will those documents need to be uploaded into the data collection system at the end of the budget period?

The data collection process will not require the data entity to upload documents. Data sources for the Performance Measures are primarily meant for the HCC's or hospital's reference. However, per the requirements of the FOA, HPP Field Project Officers may request these relevant operational documents during site visits. Awardees, HCCs, and hospitals should maintain current versions of all required data sources.

*Correction from the Live Webinar(s): While the majority of data sources do not need to be uploaded, awardees **are** required to submit their HCCs' final Preparedness Plan with the Budget Period 1 Annual Progress Report.*

Will Performance Measure targets use ranges and/or discrete numbers?

The Performance Measure goal or target refers to the ideal or recommended result based on baseline data, benchmarks, and/or program requirements. In some cases, this section indicates that the goal or target may be set by SHARPER at a later date once the data from the first budget period has been reviewed. At this time, SHARPER is still determining its methodology for setting baselines and targets. This information will be shared when it is finalized and approved.

Is it possible that the performance measures will change for Budget Period 2?

Our intention is to have consistent measures year-over-year; however, this is unknown at this time. It will depend on how the data and the analysis look. HPP will make this determination once the Budget Period 1 data analysis is complete.

How will Budget Period 1 data be used to set benchmarks?

After collecting the Budget Period 1 data, SHARPER will analyze the measures across a number of factors. Based on the analysis and programmatic needs, targets will be set. These targets may differ for different coalitions/awardees based on factors such as HCC characteristics. Until the Budget Period 1 data is collected and analyzed, we cannot confirm whether targets will be the same for all coalitions and awardees.

Will data for joint measures be collected in PERFORMS?

There is no information required to be reported to HPP on the joint measures. Information collected by PHEP on these measures will be shared with HPP.

Will the data collection system have a mechanism to collect qualitative feedback, such as a text box to gather comments on barriers and challenges?

The data collection system for Budget Period 1 is still in development. At this time, we cannot confirm if there will be a comment box for this specific qualitative feedback, but we will take this suggestion under advisement. We encourage you to contact your HPP Field Project Officer or your SHARPER analyst at any time to provide feedback on challenges related to the new performance measures. Additionally, you can email SHARPER at SHARPER@HHS.GOV.

Has the Coalition Assessment Tool (CAT) been released?

No. At this time (July 2017) the Coalition Assessment Tool (CAT) has not been released. The expected timeline for release is late summer to early fall. HPP will continue to update awardees and HCCs regarding the expected release date for the CAT.