2017-2022 Hospital Preparedness Program

Performance Measures Implementation Guidance

Office of the Assistant Secretary for Preparedness and Response

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Acronyms

AAR/IP	After-Action Report and Improvement Plan
ACF	Administration for Children and Families
ABC	At-Risk Individuals, Behavioral Health & Community Resilience Division
ASPR	Assistant Secretary for Preparedness and Response
BP	Budget Period
CDC	Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
COOP	Continuity of Operations Plan
CSC	Crisis Standards of Care
CST	Coalition Surge Test
ED	Emergency Department
EEI	Essential Elements of Information
EMS	Emergency Medical Services
EMSC	Emergency Medical Services for Children
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
ESAR-VHP	Emergency System for Advance Registration of Volunteer Health Professionals
ESF	Emergency Support Function
FOA	Funding Opportunity Announcement
FPO	Field Project Officer
GIS	Geographic Information System
HCC	Health Care Coalition
HCO	Health Care Organization
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HPP	Hospital Preparedness Program
HSEEP	Homeland Security Exercise and Evaluation Program
HST	Hospital Surge Test
IBA	Immediate Bed Availability
ICS	Incident Command System

ICU	Intensive Care Unit
IT	Information Technology
JRA	Jurisdictional Risk Assessment
LHD	Local Health Department
MCM ORR	Medical Countermeasure Operational Readiness Review
MOU	Memorandum of Understanding
NHPP	National Healthcare Preparedness Programs
NOAA	National Oceanographic and Atmospheric Administration
PHEP	Public Health Emergency Preparedness
PM	Performance Measure
POD	Point of Dispensing
RCD	Redundant Communications Drill
SHARPER	Science Healthcare Preparedness Evaluation and Research
SVI	Social Vulnerability Index
TRACIE	Technical Resources, Assistance Center, and Information Exchange
UASI	Urban Area Security Initiative
USDA	United States Department of Agriculture
VOIP	Voice over Internet Protocol
WebEOC	Web Based Emergency Operations Center

Background

The U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response (ASPR) leads the country in preparing for, responding to, and recovering from the adverse health effects of emergencies and disasters. This is accomplished by supporting the nation's ability to withstand adversity, strengthening health and emergency response systems, and enhancing national health security. ASPR's Hospital Preparedness Program (HPP) enables the health care delivery system to save lives during emergencies and disaster events that exceed the day-to-day capacity and capability of existing health and emergency response systems. HPP is the only source of federal funding for health care delivery system readiness, intended to improve patient outcomes, minimize the need for federal and supplemental state resources during emergencies, and enable rapid recovery. HPP prepares the health care delivery system to save lives through the development of health care coalitions (HCCs) that incentivize diverse and often competitive health care organizations (HCOs) with differing priorities and objectives to work together.

For the 2017-2022 cooperative agreement project period, there are two key documents that guide the program the *2017-2022 Health Care Preparedness and Response Capabilities* and the *2017-2022 Hospital Preparedness Program (HPP) - Public Health Emergency Preparedness (PHEP) Cooperative Agreement Funding Opportunity Announcement CDC-RFA-TP17-1701* described below. These two documents informed the development of the *2017-2022 Hospital Preparedness Program Performance Measures Implementation Guidance*.

2017-2022 Health Care Preparedness and Response Capabilities

ASPR developed the *2017-2022 Health Care Preparedness and Response Capabilities* to describe the high-level objectives that the health care delivery system, including HCCs, hospitals, and emergency medical services (EMS), should undertake to prepare for, respond to, and recover from emergencies. The four Health Care Preparedness and Response Capabilities are:

Capability 1: Foundation for Health Care and Medical Readiness

Goal of Capability 1: The community[1] has a sustainable HCC comprised of members with strong relationships that can identify hazards and risks and prioritize and address gaps through planning, training, exercising, and managing resources.

Capability 2: Health Care and Medical Response Coordination

Goal of Capability 2: HCOs, the HCC, their jurisdiction(s), and the Emergency Support Function (ESF)-8 lead agency plan and collaborate to share and analyze information, manage and share resources, and coordinate strategies to deliver medical care to all populations during emergencies and planned events.

Capability 3: Continuity of Health Care Service Delivery

Goal of Capability 3: HCOs, with support from the HCC and the ESF-8 lead agency, provide uninterrupted, optimal medical care to all populations in the face of damaged or disabled health care infrastructure. Health care workers are well trained, educated, and equipped to care for patients during emergencies. Simultaneous response and recovery operations result in a return to normal or, ideally, improved operations.

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[1] As the HCC is defined in Capability 1, Objective 1, Activity 1 – Define Regional Boundaries of the *2017-2012 Health Care Preparedness and Response Capabilities*.

Capability 4: Medical Surge

Goal of Capability 4: HCOs, including hospitals, EMS, and out-of-hospital providers, deliver timely and efficient care to their patients even when the demand for health care services exceeds available supply. The HCC, in collaboration with the ESF-8 lead agency, coordinates information and available resources for its members to maintain conventional surge response. When an emergency overwhelms the HCC's collective resources, the HCC supports the health care delivery system's transition to contingency and crisis surge response[2] and promotes a timely return to conventional standards of care as soon as possible.

These capabilities illustrate the range of preparedness and response activities that, if conducted, represent the ideal state of readiness in the United States. ASPR recognizes that there is shared authority and accountability for the health care delivery system's readiness that rests with private organizations, government agencies, and ESF-8, Public Health and Medical Services lead agencies. Given the many public and private entities that must come together to ensure community preparedness, HCCs serve an important communication and coordination role within their respective jurisdiction(s).

These capabilities may not be achieved solely with the funding provided through the HPP Cooperative Agreement.

2017-2022 Hospital Preparedness Program (HPP) - Public Health Emergency Preparedness (PHEP) Cooperative Agreement Funding Opportunity Announcement (FOA) CDC-RFA-TP17-1701

ASPR provides clear expectations and priorities for HPP awardees and HPP-funded HCCs in the FOA for the five-year project period that begins on July 1, 2017. The FOA provides guidance to ensure that HPP awardees focus on activities that advance progress toward meeting the goals of the four capabilities detailed in the *2017-2022 Health Care Preparedness and Response Capabilities* and document progress toward establishing or maintaining ready health care systems through strong HCCs. The FOA organizes expectations across six key domains, as listed in Appendix 1: CDC-RFA-TP17-1701 Logic Model: HPP-PHEP Cooperative Agreement.

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[2] "Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations." *Institute of Medicine of the National Academies*, 2009. Web. Accessed 19 Jul. 2016. www.nap.edu/read/12749/chapter/1.

Introduction to the 2017-2022 Hospital Preparedness Program Performance Measures Implementation Guidance

The two branches of the National Healthcare Preparedness Programs (NHPP), the Hospital Preparedness Program (HPP) and the Science Healthcare Preparedness Evaluation and Research (SHARPER), developed these performance measures (PMs). The PMs were developed to align to the core concepts of the capabilities and the FOA, to evaluate program performance and track program progress. Performance measurement is a component of a comprehensive program evaluation strategy that includes program monitoring and supplemental ad hoc evaluations. The new PMs will enable better communication of program results to elected officials and various internal and external stakeholders and inform continuous program improvement.

To measure HPP performance, a variety of measures were developed at the input-, activity-, output-, or outcome-level. While the HPP PMs have historically focused on program activities and outputs, the new PMs for 2017-2022 further target output and outcome measures to address the information needs of various stakeholders. At a high-level, HPP stakeholders can be organized into three groups based on their information needs—national-, program-, and implementation-level. For example, at the national-level, Congress, HHS and ASPR leadership, and other national stakeholders may be most interested in the preparedness of the nation's health care delivery system; at the program-level, HPP is interested in program effectiveness, appropriate use of funds, and identifying trends to continually improve the nation's preparedness; and, at the implementation-level, awardees, HCCs, and individual HCOs may be most interested in how prepared they are to respond to events in their communities.

These PMs were developed based on guidance provided in the *2017-2022 Health Care Preparedness and Response Capabilities* and the FOA. For more information on stakeholder engagement, see Appendix 2: The 2017-2022 HPP Performance Measures Development Process for more details.

Using this Document

The *2017-2022 Hospital Preparedness Program Performance Measures Implementation Guidance* document is framed for the primary users—awardees and HCCs—to foster ease of comprehension, improve information aggregation, and enable faster data collection. The intended audience for this document is any individual responsible for collecting and reporting data on awardee and HCC progress toward meeting the goals of the four capabilities detailed in the *2017-2022 Health Care Preparedness and Response Capabilities*. This document organizes the PMs into five sections:

Section 1: Input, Activity, and Output Performance Measures

This section includes PMs 1 to 11 that gauge progress at both the awardee and HCC levels in fiscal preparedness, preparedness and response planning, identification of populations with unique needs, jurisdictional engagement, and systematic learning.

Section 2: Redundant Communications Drill Performance Measures

Each HCC will conduct a redundant communications drill (RCD) semi-annually to test redundant forms of communication among its members. This section includes PMs 12 and 13 that measure whether regular RCDs are taking place, if communication is occurring between the HCC and its members, and which platforms are being used during an RCD.

Section 3: Coalition Surge Test Performance Measures

This section contains PMs 14 to 21 that use data produced while conducting the Coalition Surge Test (CST). The CST is described at the beginning of section 3. To gauge the full extent of HCC performance, ASPR selected the eight PMs in this section to assess the speed and extent to which HCCs can coordinate an evacuation exercise. The eight PMs assess participation and both time- and percent-based outcomes on the ability of HCCs to coordinate patient load-sharing across the coalition.

Section 4: Joint Performance Measures

This section contains joint PMs with HPP and the Emergency Medical Services for Children (EMSC) and the Public Health Emergency Preparedness (PHEP) programs—PMs 22, J.1, and J.2. Awardees and HCCs will not report data on these PMs to HPP. EMSC and PHEP will collect this information as part of their grants and cooperative agreements, and share the data with HPP and SHARPER.

Section 5: Select U.S. Territories and Freely Associated States Performance Measures

This section contains PMs 23 to 28 that use data produced by a Hospital Surge Test (HST) and only applies to the following U.S. Territories and Freely Associated States: American Samoa, Commonwealth of Northern Marianas, U.S. Virgin Islands, Federated States of Micronesia, Republic of Palau, and Republic of the Marshall Islands. The U.S. Territories of Guam and Puerto Rico are not included in this category and shall report on all PMs except 23 to 28. For more information on which PMs from other sections apply to these awardees, please see Overview of Performance Measures for Select U.S. Territories and Freely Associated States.

Performance Measure Guidance

For each PM, there is a full description of the measure and instructions on how to collect the relevant data. With the exception of two previously used joint measures (J.1 and J.2), the guidance for each PM includes the following:

- **Performance Measure:** The section will begin with the PM number and the PM itself.
- **Goal or Target:** This section will outline the ideal or recommended result based on baseline data, benchmarks, or program requirements. In some cases, this section indicates that the goal or target may be set by SHARPER at a later date after data from the first budget period has been reviewed.
- **Operational Intent:** The operational intent provides a brief description of the purpose of the measure and its link to preparedness program priorities.
- **Data Points:** This section includes a table that describes the individual data points that must be reported to calculate the measure, including the data entity, data source, and response.
  - **Data Entity:** This column will indicate organization(s) providing the data for the measure—awardee, HCC, or hospital.
  - **Data Source:** The data source includes examples of documentation or systems where PM data is documented and managed (e.g., exercise materials, meeting notes, or financial statements). Data sources should be archived for future verification purposes.
  - **Response:** The response column outlines the format for reporting on the required data points.
- **Definitions and Interpretation:** Specific language throughout the PM guidance is linked to a detailed definition within that section. These definitions and interpretations provide guidance on how to interpret key terms and phrases within the context of the PM.

ASPR encourages HCCs, HCOs, and other stakeholders reporting on these PMs to consult their field project officer (FPO) to receive technical assistance and resources for completing these measures.

Baseline and Target/Goal Setting

SHARPER will use the data reported for Budget Period 1 to establish a baseline for awardees and HCCs, unless otherwise noted in the Goal or Target section of the PM. Targets and goals will be set by SHARPER based on baseline data, benchmarks, and/or program requirements. Achievement in future budget years 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.

HPP Performance Measure Requirements

The following HPP PM requirements apply to all awardees and HCCs, except for select U.S. Territories and Freely Associated States (American Samoa, Commonwealth of Northern Marianas, U.S. Virgin Islands, Federated States of Micronesia, Republic of Palau, and Republic of the Marshall Islands).

Annual Requirement to Exercise Coalition Surge Test

All HCCs that receive HPP funding are required to use the CST annually. Data from the CST will be used to respond to PMs 14 to 21, collected using the associated evaluation tools as identified in this implementation guidance. The detailed CST manual and evaluation tools can be viewed online at https://www.phe.gov/Preparedness/planning/hpp/Pages/coaltion-tool.aspx. In the event that an HCC has a real-world evacuation of at least 20 percent of a coalition's total staffed acute care bed capacity during the reporting year, the HCC can use the data from the real-world evacuation to respond to each applicable PM. The HCC must still submit an After-Action Report and Improvement Plan (AAR/IP) that specifically responds to each applicable PM if a real-world evacuation occurs during the reporting year.

Data Collection System

HPP and PHEP are working with HHS Administration for Children and Families (ACF) to develop a new joint data collection system where awardees will enter responses to the data points listed in this implementation guidance. At a future date, HPP will provide specific guidance on using the new joint data collection system.

Optimized HCCs with Response Capabilities

HCCs must collaborate with a variety of stakeholders to ensure the community has the necessary medical equipment and supplies, real-time information, communication systems, and trained and educated health care personnel to respond to an emergency. These stakeholders include core HCC members—hospitals, emergency medical services (EMS), emergency management organizations, and public health agencies—additional HCC members, and the ESF-8 lead agency. The HCC should include a diverse membership to ensure a successful whole community response. If segments of the community are unprepared or not engaged, there is greater risk that the health care delivery system will be overwhelmed. As such, the HCC should liaise with the broader response community on a regular basis. The list of HCC membership, delineating core and additional HCC members, is included in Appendix 3: List of Core and Additional HCC Member Types.

Overview of Performance Measures for Select U.S. Territories and Freely Associated States

These measures only apply to the U.S. Territories of American Samoa, Commonwealth of Northern Marianas, and U.S. Virgin Islands, and the Freely Associated States of Federated States of Micronesia, Republic of Palau, and Republic of the Marshall Islands. The U.S. Territories of Guam and Puerto Rico are not included in this category and shall report on all measures except 23 to 28. The select U.S. Territories and Freely Associated States have unique risk profiles, resource constraints, supply chains, and regulatory requirements compared to the rest of the awardees and HCCs receiving HPP funding.

In the following table, the reporting requirements for these select U.S. Territories and Freely Associated States are cross-walked to each PM: a 'Yes' indicates the PM shall be reported while a 'No' indicates the PM is not required to be reported.

Section	PM	Select U.S. Territories (American Samoa, Commonwealth of Northern Marianas, and U.S. Virgin Islands)	Freely Associated States (Federated States of Micronesia, Republic of Palau, and Republic of the Marshall Islands)
1	1	Yes	Yes
1	2	No	No
1	3-5	Yes	Yes
1	6	Yes	No
1	7	No	No
1	8-11	Yes	Yes
2	12-13	Yes	Yes
3	14-21	No	No
4	22	Yes	Yes
4	J.1	No	No
4	J.2	Yes	Yes
5	23-28	Yes	Yes

Table 1: Measures Required for U.S. Territories and Freely Associated States

The HST will only be annually required for select U.S. Territories and Freely Associated States. 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 detailed HST manual and evaluation tools can be viewed online at https://www.phe.gov/Preparedness/planning/hpp/surge/Pages/default.aspx.

Section 1: Input, Activity, and Output Performance Measures

This section contains input, activity, and output performance measures (PMs) aligned to the requirements of the *2017-2022 Health Care Preparedness and Response Capabilities* and the FOA. For a crosswalk of PMs to the *2017-2022 Health Care Preparedness and Response Capabilities*, see Appendix 4: Crosswalk of Performance Measures to 2017-2022 Health Care Preparedness and Response Capabilities.

The following table lists the Data Entity—the organizational level at which the data are captured (awardee or HCC)—and PM type for each PM:

PM	Data Entity	PM Type
1	HCC	Input
2	Awardee	Activity
3	HCC	Input
4	HCC	Output
5	HCC	Output
6	Awardee & HCC	Activity
7	Awardee & HCC	Activity
8	Awardee	Activity
9	HCC	Activity
10	HCC	Activity
11	Awardee	Output

Table 2: Section 1 Data Entity and PM Type

The definitions for the PM types are:

- **Input:** Resources that are required to support HPP, including staff and volunteers, funding, facilities, and equipment;
- **Activity:** Actions that use or involve HPP inputs; and,
- **Output:** Products and services produced by HPP activities.

Performance Measure 1

Percent of funding each HCC receives from the awardee, other federal sources, and non-federal sources.

Goal or Target

SHARPER will establish a baseline based on performance data collected in the first budget period which will be used to set targets and goals for subsequent budget periods.

Operational Intent

Provides insight into the amount and composition of funding each HCC receives to better enable linking HCC funding and program outcomes, as well as HCC sustainability (diversity of funding). A greater diversity of funding for preparedness and response strengthening activities means less dependency on any one resource and a lower funding risk should one resource be decreased or eliminated. While in-kind support is critical to many HCCs, consistently quantifying the value of in-kind support is difficult and burdensome. Therefore, this measure only seeks to capture the various types of in-kind support (and not value) each HCC receives from sources other than the awardee to help assess diversity of support.

Data Reporting

Each HCC should report the following data to the awardee. Awardees should report the following data on behalf of each HCC to SHARPER. SHARPER will calculate percentages.

Data Point	Data Entity	Data Source	Response
Total HPP funding amount each HCC received from the awardee	HCC	HCC Operating Budget	HCC Name:_____ $_____
Total funding each HCC received from other federal sources	HCC	HCC Operating Budget	HCC Name:_____ $_____
Total funding each HCC received from non-federal sources	HCC	HCC Operating Budget	HCC Name:_____ $_____
Total funding each HCC received from all sources	HCC	HCC Operating Budget	HCC Name:_____ $_____
The HCC receives in-kind support from sources other than the awardee in the form of (check all that apply)	HCC	HCC Operations Documents	HCC Name:_____ ☐ Physical Space ☐ Equipment/Supplies ☐ Services ☐ Labor Hours ☐ Other ☐ None received

Table 3: Data Reporting for Performance Measure 1

Definitions and Interpretation

- **Funding:** In this case funding means the program funds distributed by HPP to HCCs. Funding includes all allocations to the HCC during the annual budget period from July 1 to June 30. The percent is calculated by SHARPER from the data points collected from the awardee on behalf of the HCC. Carryover funding is not reported under allocations.
- **From the awardee:** The total amount of funding directly made available to the HCC from the awardee or its agent (e.g., if the awardee distributes funding to a state hospital association that

then funds the HCC, the HCC would report the amount of funding made available from the state hospital association).

- **Other federal sources:** The total amount of funding directly made available to the HCC from other federal sources (e.g., PHEP and/or Urban Area Security Initiative funding (UASI)).
- **Non-federal sources:** The total amount of funding directly made available to the HCC from other non-federal sources (e.g., state or municipal funding, non-federal public-private partnership, or nonprofit or foundation grant).
- **In-kind support from sources other than the awardee:** Any non-monetary support for HCC activities received from sources other than the awardee. For further definitions of in-kind support, see 45 Code of Federal Regulation (CFR), Part 92.24 at https://www.gpo.gov/fdsys/pkg/CFR-2005-title45-vol1/pdf/CFR-2005-title45-vol1-sec92-24.pdf.
- **Physical space:** For example, meeting space, exercise space, offices, storage, etc.
- **Equipment/Supplies:** For example, communication or office equipment, or administrative supplies.
- **Services:** For example, printing, logistical, transportation, accounting, or administrative services.
- **Labor Hours:** For example, labor hours of HCC coordinator or other HCC members working on HCC-related activities, if the individual is a volunteer or employed by a member organization.

Performance Measure 2

Number of calendar days from **start of budget period** for **awardees to execute subawards with each HCC**.

Goal or Target

Awardees must execute subawards with each HCC within 90 calendar days from the start of each budget period. SHARPER will evaluate data from the first budget period and determine if the 90-day benchmark needs to be adjusted for subsequent budget periods. **ASPR will use this measure as a benchmark to assess achievement of preparedness goals for the health care system. Failure to achieve this benchmark may result in withholding of funding amounts in succeeding years pursuant to Section 319C-1(g)(5) of the Public Health Service Act.**

Operational Intent

Provides insight into fiscal preparedness and ability of awardees to execute subawards to HCCs in a timely manner. How quickly HCCs can begin to execute programming and contracts may impact their ability to perform on an annual basis. The sooner implementing groups have the subaward in place, the sooner they are able to begin work and access HPP funding, the greater likelihood of having sufficient time to complete subaward activities.

Data Reporting

Awardees should report the associated data point for this PM for <u>each</u> HCC in their jurisdiction to SHARPER. SHARPER will calculate duration from start of budget period.

Data Point	Data Entity	Data Source	Response
Date(s) subaward(s) are executed with each HCC	Awardee	Executed subaward agreements	HCC Name:_____ Date Executed:_____

Table 4: Data Reporting for Performance Measure 2

Definitions and Interpretation

- **Number of calendar days:** Calendar days, inclusive of weekends, holidays, and leap day (if applicable).
- **Start of budget period:** July 1 is the start date of each budget period. If extenuating circumstances prevent the timely award of HPP awards to awardees before or on this date, this start date will be adjusted to reflect the federal government's delay in awarding funds to the awardees.
- **Awardees to execute subawards:** The regular process by which awardees issue a contract, cooperative agreement, or grant (collectively referred to as a subaward) which allows an HCC to legally enter into obligations or expend funding. Reimbursement of pre-award costs generally is not allowed.
- **With each HCC:** While the awardee is responsible for reporting this measure, the date of subaward execution should only be calculated from when the HCC and <u>only</u> the HCC receives an executed subaward from the awardee. If an awardee uses a pass through entity such as a 501(c)(3) or a state hospital association to subsequently execute a subaward to the HCC, the date of executed subaward is when the HCC ultimately receives an executed subaward.

Performance Measure 3

Membership representation rate of HCC core (acute care Hospitals, EMS, Emergency Management, Public Health) and additional member organizations by member type.

Goal or Target

Per the FOA, HCCs must ensure the following core members are represented. Further, awardees are not permitted to use HPP funds to make subawards to any HCC that does not meet the core membership requirements, including, at least, the following:

- Hospitals (a minimum of two acute care hospitals)
- EMS (including interfacility and other non-EMS patient transport systems)
- Emergency management organizations
- Public health agencies

SHARPER will establish a baseline for the participation of additional members based on performance data collected in the first budget period which will be used to set targets and goals for subsequent budget periods.

Operational Intent

Determine if HCCs meet program requirements for core membership, assess membership rates by member type, and track HCC membership trends over time. ASPR understands that HCCs may have different membership compositions based on population characteristics, geography, and types of hazards. ASPR recognizes that more members do not necessarily mean greater capacity to prepare and respond to hazards. Therefore, the intent of this measure is to assess HCC membership representation as appropriate for the needs of their communities and to inform the program knowledge base about the appropriate mix of member organizations and organization types to respond to community needs.

Data Reporting

Each HCC should report the following data to the awardee. Awardees should report the following data on behalf of each HCC to SHARPER. SHARPER will calculate percentages. See Appendix 3: List of Core and Additional HCC Member Types for a full list of member types.

Data Point	Data Entity	Data Source	Response
Core member organizations represented in the HCC, disaggregated by member type	HCC	HCC Governance Documents	HCC core member organizations' type, legal name (no abbreviations), and address
Total number of core member organizations within HCC boundaries, disaggregated by member type	HCC	Awardee provided list or survey	HCC member organizations' type, legal name (no abbreviations), and address
Additional member organizations represented in the HCC, disaggregated by member type	HCC	HCC Governance Documents	HCC additional member organizations' type, legal name (no abbreviations), and address

Data Point	Data Entity	Data Source	Response
Total number of additional member organizations within HCC boundaries, disaggregated by member type	HCC	Awardee provided list or survey	HCC additional member organizations' type, legal name (no abbreviations), and address

Table 5: Data Reporting for Performance Measure 3

Definitions and Interpretation

- **Membership representation:** As evidenced by memoranda of understanding (MOU), letters of agreements, and/or attendance at an HCC meeting in the past budget period. Representation can be achieved through an authorized representative from the member organization or an authorized representative of a group or network of member organizations (e.g., an integrated health care delivery system or corporate network). In instances where there are multiple entities of an HCC member type, there may be a subcommittee structure that establishes a lead entity to communicate common interests to the HCC (e.g., multiple dialysis centers forming a subcommittee). If a subcommittee lead participates in an HCC meeting, for example, the members engaged in that subcommittee (through MOU, letters of agreement, and/or attendance at a subcommittee meeting in the past budget year) are also considered represented.
- **HCC core member organizations:** Core members are defined in the *2017-2022 Health Care Preparedness and Response Capabilities* as acute care hospitals, EMS, emergency management, and public health. See Appendix 3: List of Core and Additional HCC Member Types for a full list.
- **Acute care hospitals:** A hospital that provides inpatient medical care and other related services for surgery, acute medical conditions or injuries (usually for a short term illness or condition).
- **HCC additional member organizations:** See Appendix 3: List of Core and Additional HCC Member Types for a full list.

Performance Measure 4

Percent of HCCs that have a complete and approved Preparedness Plan.

Goal or Target

One hundred percent of HCCs have a draft preparedness plan completed by April 1, 2018, and a complete Preparedness Plan by the end of the first budget period with 100 percent approval by the core member organizations of each HCC every budget period. **ASPR will use this measure as a benchmark to assess achievement of preparedness goals for the health care system. Failure to achieve this benchmark may result in withholding of funding amounts in succeeding years pursuant to Section 319C-1(g)(5) of the Public Health Service Act.**

One hundred percent of additional member organizations have been provided an opportunity to provide input into the Preparedness Plan, and 100 percent of core and additional member organizations have received a final copy of the Preparedness Plan.

Operational Intent

Determine if HCCs have a Preparedness Plan approved by member organizations as described in Capability 1, Objectives 1 to 3 of the *2017-2022 Health Care Preparedness and Response Capabilities*. One of the key roles of an HCC is to promote collaboration across its membership in order to prepare communities for emergencies and hazards. A complete and approved Preparedness Plan provides evidence that HCCs are performing this role for their communities. Specific requirements for the Preparedness Plan are delineated in the FOA and included in Appendix 5: Required Components of Preparedness and Response Plans.

Data Reporting

Each HCC should report the following data to the awardee. Awardees should report the following data on behalf of each HCC to SHARPER. SHARPER will calculate percentages.

Data Point	Data Entity	Data Source	Response
The HCC has a complete Preparedness Plan with the required components	HCC	Preparedness Plan	HCC Name:_____ ☐ Yes ☐ No
The HCC has a Preparedness Plan that has been approved by all of its core member organizations	HCC	Preparedness Plan	HCC Name:_____ ☐ Yes ☐ No
All of the HCC's additional member organizations have been given an opportunity to provide input into the Preparedness Plan, and all member organizations have received a final copy of the plan	HCC	Preparedness Plan	HCC Name:_____ ☐ Yes ☐ No

Table 6: Data Reporting for Performance Measure 4

Definitions and Interpretation

- **Complete Preparedness Plan:** A complete Preparedness Plan has all of the required components identified in the FOA. HCCs may elect to address the components associated with the Preparedness Plan in one document, in combination with the Response Plan, or in multiple documents, but all components must be documented.
- **Approved Preparedness Plan:** For core member organizations, approval is considered to be a formal process by which an authorized representative of each core member organization signs the Preparedness Plan.
- **Required Components:** Complete Preparedness and Response Plans have all of the required components identified in the FOA as well as the *2017-2022 Health Care Preparedness and Response Capabilities*. See Appendix 5: Required Components of Preparedness and Response Plans for more information. Additional guidance on the components of the Preparedness and Response Plans can be found in the *2017-2022 Health Care Preparedness and Response Capabilities.*
- **HCC core member organizations:** Core members are defined in the *2017-2022 Health Care Preparedness and Response Capabilities* as acute care hospitals, EMS, emergency management, and public health. See Appendix 3: List of Core and Additional HCC Member Types for a full list.
- **HCC additional member organizations:** See Appendix 3: List of Core and Additional HCC Member Types for a full list.

Performance Measure 5

Percent of HCCs that have a [complete](#) and [approved](#) Response Plan.

Goal or Target

One hundred percent of HCCs have a [complete](#) Response Plan by the end of the second budget period with, 100 percent [approval](#) by the [core member organizations](#) of each HCC for every budget period.

One hundred percent of additional member organizations have been provided an opportunity to provide input into the Response Plan, and 100 percent of core and additional member organizations have received a final copy of the Response Plan.

Operational Intent

Determine if HCCs have a Response Plan [approved](#) by member organizations as described in Capability 2, Objective 1, Activities 1 and 2 of the *[2017-2022 Health Care Preparedness and Response Capabilities](#)*. One of the key roles of an HCC is to promote collaboration across its membership in order to better respond to emergencies. A complete and approved Response Plan provides evidence that HCCs are performing this role for their communities. Specific requirements for the Response Plan are delineated in the FOA (see [Appendix 5: Required Components of Preparedness and Response Plans](#) for more information) and may be updated in future budget years' continuation guidance.

Data Reporting

Each HCC should report the following data to the awardee. Awardees should report the following data on behalf of each HCC to SHARPER. SHARPER will calculate percentages.

Data Point	Data Entity	Data Source	Response
The HCC has a [complete](#) Response Plan with the [required components](#)	HCC	Response Plan	HCC Name:_____ ☐ Yes ☐ No
The HCC has a Response Plan that has been [approved](#) by all of its core member organizations	HCC	Response Plan	HCC Name:_____ ☐ Yes ☐ No
All of the HCC's [additional member organizations](#) have been given an opportunity to provide input into the Response Plan, and all member organizations have received a final copy of the plan	HCC	Response Plan	HCC Name:_____ ☐ Yes ☐ No

Table 7: Data Reporting for Performance Measure 5

Definitions and Interpretation

- **Complete Response Plan:** A complete Response Plan has all of the required components identified in the FOA. HCCs may elect to address the components associated with the Response Plan in one document, in combination with the Preparedness Plan, or in multiple documents; however, all components must be documented.
- **Approved Response Plan:** For core member organizations, approval is considered to be a formal process by which an authorized representative of each core member organization signs the Response Plan.

- **Required Components:** Complete Preparedness and Response Plans have all of the required components identified in the FOA as well as the *2017-2022 Health Care Preparedness and Response Capabilities*. See Appendix 5: Required Components of Preparedness and Response Plans for more information. Additional guidance on the components of the Preparedness and Response Plans can be found in the *2017-2022 Health Care Preparedness and Response Capabilities.*
- **HCC core member organizations:** Core members are defined in the *2017-2022 Health Care Preparedness and Response Capabilities* as acute care hospitals, EMS, emergency management, and public health. See Appendix 3: List of Core and Additional HCC Member Types for a full list.
- **HCC additional member organizations:** See Appendix 3: List of Core and Additional HCC Member Types for a full list.

Performance Measure 6

Part A: Percent of awardees that obtain de-identified data from emPOWER at least once every six months to identify numbers of individuals with electricity-dependent medical and assistive equipment for planning purposes.

Part B: Percent of HCCs that obtain de-identified data from emPOWER at least once every six months to identify numbers of individuals with electricity-dependent medical and assistive equipment for planning purposes.

Goal or Target

SHARPER will establish a baseline based on performance data collected in the first budget period which will be used to set targets and goals for subsequent budget periods.

Operational Intent

Determine if awardees and HCCs have up-to-date data on populations with electricity-dependent medical and assistive equipment in their jurisdiction for planning purposes. Awardees and HCCs should be planning how to address the needs of these populations during an emergency. Numbers of individuals with electricity-dependent medical and assistive equipment from emPOWER represents a minimum of potential population needs in an emergency. Awardees and HCCs should at least plan for the populations' needs based on emPOWER data, although actual needs of the population are certainly greater since emPOWER data does not capture populations with electricity-dependent medical and assistive equipment covered by Medicaid, including children. Awardees may also consider obtaining similar information from their Medicaid programs and health insurers with significant market share in their communities.

Data Reporting

Each HCC should report the second data point to the awardee. Awardees should report both data points to SHARPER. SHARPER will calculate percentages.

Data Point	Data Entity	Data Source	Response
The awardee obtains de-identified data from emPOWER at least once every six months to identify numbers of individuals with electricity-dependent medical and assistive equipment for planning purposes	Awardee	Meeting notes, agendas, or other operational documents	☐ Yes ☐ No
The HCC obtains de-identified data from emPOWER at least once every six months to identify numbers of individuals with electricity-dependent medical and assistive equipment for planning purposes	HCC	Meeting notes, agendas, or other operational documents	HCC Name:_____ ☐ Yes ☐ No

Table 8: Data Reporting for Performance Measure 6

Definitions and Interpretation

- **Obtain de-identified data from emPOWER:** emPOWER data can be accessed at https://empowermap.hhs.gov/. De-identified data are HIPAA compliant.
- **emPOWER:** emPOWER, developed by HHS ASPR, is an integrated platform that provides progressively dynamic data and mapping tools that can help state and local health departments, and their partners, to better anticipate, mitigate, plan for, and respond to the potential needs of at-risk persons with access and functional needs electricity-dependent medical and assistive equipment prior to, during, and after a disaster. One of its tools, the HHS emPOWER Map, is a publicly-available resource that integrates de-identified Medicare billing-data, real-time National Oceanic and Atmospheric Administration (NOAA) severe weather tracking, and geographic information system (GIS) mapping to highlight the number of at-risk individuals that use electrically-dependent, life-maintaining, and assistive durable medical equipment in geographic areas down to the zip code level.[3]
- **At least once every six months:** Each budget period is 12 months. An awardee or HCC should access emPOWER data at least once every six months.
- **Identify numbers of individuals with electricity-dependent medical and assistive equipment:** The emPOWER map provides the number of individuals with electricity-dependent medical and assistive equipment. If the number of individuals is less than 11, emPOWER reports 11 individuals are present in a zip code; numbers above 10 individuals are reported accurately.

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[3] "The HHS emPOWER Initiative: Emergency Preparedness Tools Addressing the Needs of Energy Dependent, At-Risk Populations." *National Association of County & City Health Officials (NACCHO).* Accessed on 7 Dec. 2016. http://nacchopreparedness.org/the-hhs-empower-initiative-emergency-preparedness-tools-addressing-the-needs-of-energy-dependent-at-risk-populations-2/.

Performance Measure 7

Part A: Percent of awardees that obtain data from the Social Vulnerability Index to estimate the populations with a higher likelihood of having access and functional needs for planning purposes at least once per year.

Part B: Percent of HCCs that obtain data from the Social Vulnerability Index to estimate the populations with a higher likelihood of having access and functional needs for planning purposes at least once per year.

Goal or Target

SHARPER will establish a baseline based on performance data collected in the first budget period which will be used to set targets and goals for subsequent budget periods.

Operational Intent

The Social Vulnerability Index is one of the sources coalitions should use to estimate populations with a higher likelihood of having access and functional needs for planning purposes. Determine if awardees and HCCs have up-to-date data on populations with access and functional needs in their jurisdiction for planning purposes.

ASPR outlines the importance of preparedness and response planning for individuals with access and functional needs on the Public Health Emergency website: "During a disaster, it has been observed that certain at-risk individuals, specifically those with access and functional needs, have required additional response assistance before, during, and after an incident. These additional considerations for at-risk individuals with access and functional needs are vital towards inclusive planning for the whole community, and have been mandated for inclusion in federal, state, territorial, tribal, and local public health emergency plans by the Public Health Service Act. Such plans must also meet applicable requirements of the Americans with Disabilities Act."[4]

Data Reporting

Each HCC should report the second data point to the awardee. Awardees should report both data points to SHARPER. SHARPER will calculate percentages.

Data Point	Data Entity	Data Source	Response
The awardee obtains data from the Social Vulnerability Index at least once per year to estimate populations with a higher likelihood of having access and functional needs	Awardee	Meeting notes, agendas, or other operational documents	☐ Yes ☐ No

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[4] Access and Functional Needs - PHE. ASPR. 2016. Available at: http://www.phe.gov/Preparedness/planning/abc/Pages/afn-guidance.aspx. Accessed November 10, 2016.

Data Point	Data Entity	Data Source	Response
The HCC obtains data from the Social Vulnerability Index at least once per year to estimate populations with a higher likelihood of having access and functional needs	HCC	Meeting notes, agendas, or other operational documents	HCC Name:_____ ☐ Yes ☐ No

Table 9: Data Reporting for Performance Measure 7

Definitions and Interpretation

- **Census/Social Vulnerability Index:** The Social Vulnerability Index can be accessed at http://svi.cdc.gov/map.aspx. The index contains information on 14 population variables with access and functional needs drawn from the Census and American Community Survey. The Census data is updated every decade and the American Community Survey is updated annually. The SVI provides an estimate of the access and functional needs in a community across four domains derived from the Census and the American Community Survey: Socioeconomic status (below the poverty line; unemployed; low income; adults without a high school diploma), Household Composition & Disability (elderly; children; civilian with a Disability; single parent households), Minority Status & Language (minority households and speak English 'less than well'), and Housing & Transportation (individuals in group homes; high density housing; mobile homes; high density households; and households without vehicles).
- **Population with access and functional needs:** Access-based needs: All people must have access to certain resources, such as social services, accommodations, information, transportation, medications to maintain health, and so on. Function-based needs: Function-based needs refer to restrictions or limitations an individual may have that require assistance before, during, and/or after a disaster or public health emergency.
- **At least once per year:** The Social Vulnerability Index is updated annually. An awardee or HCC should access the index at least once per year.

Performance Measure 8

Percent of awardees that have <u>provided an opportunity for each HCC to review and provide input</u> to the awardee's <u>ESF-8 preparedness and response plan</u>.

Goal or Target

SHARPER will establish a baseline based on performance data collected in the first budget period which will be used to set targets and goals for subsequent budget periods.

Operational Intent

One of the key components of successful community preparedness is a shared understanding of the roles and processes for preparing and responding to emergencies. This measure will assess engagement of HCCs into the awardee-level <u>ESF-8 plans</u>.

Data Reporting

Awardees should report the following data to SHARPER. SHARPER will calculate percentages.

Data Point	Data Entity	Data Source	Response
The awardee has <u>provided an opportunity for each HCC to review and provide input </u>to the awardee's <u>ESF-8 preparedness and response plan</u>	Awardee	Meeting notes or agenda, website posting, or other documents	Name of HCC:_____ ☐ Yes ☐ No

Table 10: Data Reporting for Performance Measure 8

Definitions and Interpretation

- **Provided an opportunity for each HCC to review and provide input:** Opportunity for the HCC to 1) review the ESF-8 plan during development or 2) update and provide written or oral comments to the awardee or the awardee's designated representative on the plan.
- **Emergency Support Function-8 (ESF-8) – Public Health and Medical Services Annex:** ESF-8 (Public Health and Medical Services) provides the mechanism for coordinated federal assistance to supplement state, tribal, and local resources in response to the following:
    - Public health and medical care needs
    - Veterinary and/or animal health issues in coordination with the U.S. Department of Agriculture (USDA)
    - Potential or actual incidents of national significance
    - A developing potential health and medical situation[5]
- **ESF-8 preparedness and response plan:** ESF-8 (Public Health and Medical Services) provides the mechanism for coordinated federal assistance to supplement state, tribal, and local resources in response to the following: public health and medical care needs; veterinary and/or animal health issues in coordination with the U.S. Department of Agriculture; potential or actual incidents of national significance; and, a developing potential health and medical situation.

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[5] "<u>Emergency Support Functions</u>" *Public Health Emergency,* 2 Jun. 2015. Web. Accessed

12 Sept. 2016. http://www.phe.gov/Preparedness/support/esf8/Pages/default.aspx#8.

Performance Measure 9

Percent of HCCs engaged in their awardee's jurisdictional risk assessment.

Goal or Target

Each HCC responds 'yes' at least one time between the start of BP1 and the end of BP3.

Operational Intent

ASPR requires all HPP awardees to participate in or complete a jurisdiction's risk assessment (JRA) in conjunction with their HCCs at least once every five years. The JRA is a critical input into a community's emergency planning process, identifying hazards, vulnerabilities, and risks. This measure will assess if HCCs are engaged in the development of JRAs.

Data Reporting

Each HCC should report the following data to the awardee. Awardees should report the following data on behalf of each HCC to SHARPER. SHARPER will calculate percentages.

Data Point	Data Entity	Data Source	Response
The HCC has provided input into its awardee's jurisdictional risk assessment	HCC	Written communications, meeting notes, or other operational documents	HCC Name:_____ ☐ Yes ☐ No

Table 11: Data Reporting for Performance Measure 9

Definitions and Interpretation

- **Engaged:** Provided meaningful opportunity to review and provide input to the awardee during the development or update of the jurisdictional risk assessment.
- **Jurisdictional risk assessment (JRA):** Awardees are required to coordinate the completion of JRAs to identify potential hazards, vulnerabilities, and risks within the community, including interjurisdictional (i.e., cross-border) risks as appropriate, that specifically relate to the public health, medical, and mental/behavioral systems and the functional needs of at-risk individuals.

Performance Measure 10

Percent of HCCs where areas for improvement have been identified from HCC and member organizations' own exercises or real-world events and the HCCs' preparedness and response plans have been revised to reflect improvements.

Goal or Target

SHARPER will establish a baseline based on performance data collected in the first budget period which will be used to set targets and goals for subsequent budget periods.

Operational Intent

In order to improve whole community preparedness, HCCs must continuously learn and, where appropriate, systematically inform planning efforts using lessons learned from exercises, JRAs, or other activities. HPP expects awardees and HCCs to operationalize this type of systematic learning. Therefore, this measure was introduced to assess the ability of HCCs to integrate continuous learning from exercises and events.

Data Reporting

Each HCC should report the following data to the awardee. Awardees should report the following data on behalf of each HCC to SHARPER. SHARPER will calculate percentages.

Data Point	Data Entity	Data Source	Response
The HCC provides an opportunity for member organizations to share lessons learned from their facility's drills and exercises to inform coalition planning	HCC	Meeting notes, exercise or drill debrief documents, or AAR/IPs	HCC Name:_____ ☐ Yes ☐ No
The HCC has identified areas for improvement from HCC exercises or real-world events	HCC	Meeting notes, exercise or drill debrief documents, or AAR/IPs	HCC Name:_____ ☐ Yes ☐ No
If yes, the HCC has revised its preparedness and response plans in the past year to reflect improvements	HCC	Preparedness and Response Plans	HCC Name:_____ ☐ Yes ☐ No

Table 12: Data Reporting for Performance Measure 10

Definitions and Interpretation

- **Areas for improvement:** The concrete, actionable steps outlined in an improvement plan (IP) that are intended to resolve preparedness gaps and shortcomings experienced in exercises or real-world events.
- **Meeting notes:** Any written documentation describing the content and events—discussions, presentations, etc.—of a meeting held by an HCC or its member organizations.
- **Exercise or drill debrief documents:** Any documentation describing or analyzing the results of an exercise or drill conducted by an HCC or its member organizations.

- **AAR/IPs:** An After Action Report and Improvement Plan (AAR/IP) is used to provide feedback to participating entities on their performance during an exercise. The AAR/IP summarizes exercise events and analyzes performance of the tasks identified as important during the planning process. It also evaluates achievement of the selected exercise objectives and demonstration of the overall capabilities being validated. The IP portion of the AAR/IP includes corrective actions for improvement, timelines for implementation of corrective actions, and assignment to responsible parties. AAR/IPs should follow Homeland Security Exercise and Evaluation Program (HSEEP) principles and HPP will provide an optional template for future use.[6]
- **Preparedness Plan:** A Preparedness Plan meets the required components identified in the FOA. This includes information collected on hazard vulnerabilities and risks, resources, gaps, needs, and legal and regulatory considerations. The HCC Preparedness Plan enhances preparedness and risk mitigation through cooperative activities based on common priorities and objectives.
- **Response Plan:** A Response Plan meets the required components identified in the FOA. An HCC Response Plan describes HCC operations that support strategic planning, information sharing, and resource management. The plan also describes the integration of these functions with the ESF-8 lead agency to ensure information is provided to local officials and to effectively communicate and address resource and other needs requiring ESF-8 assistance.

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[6] "Phase 4: After Action Report and Improvement Planning*." City and County of San Francisco Department of Emergency Management*. Accessed 7 Dec. 2016. http://sfdem.org/phase-4-after-action-report-and-improvement-planning-0.

Performance Measure 11

Percent of awardees with a complete, jurisdiction-wide protocol that delineates a) the appropriate allocation of scarce resources during crises and b) local and regional crisis standards of care (CSC) planning and implementation efforts.

Goal or Target

One hundred percent of awardees with a complete CSC protocol by the end of the five-year project period.

Operational Intent

Assess how many awardees have a formalized CSC protocol by the end of the five-year project period.

Data Reporting

Awardees should report the following data to SHARPER. SHARPER will calculate percentages.

Data Point	Data Entity	Data Source	Response
The awardee has a complete, jurisdiction-wide protocol that delineates a) the appropriate allocation of scarce resources during crises and b) local and regional crisis standards of care (CSC) planning and implementation efforts	Awardee	CSC Protocol	☐ Complete ☐ In progress, but not yet complete ☐ No protocol

Table 13: Data Reporting for Performance Measure 11

Definitions and Interpretation

- **Complete, jurisdiction-wide protocol that delineates a) the appropriate allocation of scarce resources during crises and b) local and regional crisis standards of care (CSC) planning and implementation efforts:** By the conclusion of the five-year project period, HPP awardees must document their processes to oversee jurisdictional crisis standards of care (CSC) planning and to coordinate all local or regional planning efforts. HPP awardees must be prepared to submit documentation to their FPOs and ASPR's Technical Resource, Assistance Center, and Information Exchange (TRACIE) detailing these processes upon request. Further, HPP awardees must ensure the documentation includes:
    - Efforts undertaken to promote a uniform approach to establishing the ethical and legal frameworks necessary for CSC planning and implementation, for example, liability protections and specific rules and laws that might need modification or suspension to support CSC implementation, such as to broaden scope of practice or relax interstate licensure requirements;
    - Efforts undertaken to promote community engagement and discussion related to CSC planning;
    - Evidence of jurisdictional support of crisis surge response, including specific methodologies to allow for the expansion of health care service delivery, including establishment of alternate care facilities, adjustment of prescribing practices, and amendment of EMS protocols;

- Efforts undertaken to socialize and describe CSC planning in a whole-of-government context, including discussions with elected officials and other government leaders; and,
- The process used to ensure provision of consistent and uniform clinical guidance for scarce resource conditions.

HCCs also play a role in CSC planning. By the end of the five-year project period, each HPP-funded HCC must document its plan for implementing CSC, integrating EMS, hospital, public health, and emergency management policies related to situations in which the usual delivery of health care services is not possible due to disaster conditions. HCCs must be prepared to submit the documentation regarding this plan to an HPP FPO upon request. HCCs must include in the documentation:

- The key stakeholders involved in the planning, including a description of how these stakeholders integrate with each other to ensure a coordinated response to crisis conditions;
- Efforts undertaken to promote provider engagement in CSC planning;
- Activities to support the implementation of crisis care decision-making by EMS agencies, including dispatch, transport, and treatment decisions; and,
- Activities to support the implementation of crisis care decision-making by hospitals and other health care entities, especially as they relate to managing limited resources and the integration of crisis strategies into surge capacity planning and incident management.

Section 2: Redundant Communications Drill Performance Measures

This section contains performance measures (PMs) that use data produced by a Redundant Communications Drill (RCD) that is a requirement of the *2017-2022 Health Care Preparedness and Response Capabilities* and the FOA. For a crosswalk of PMs to the *2017-2022 Health Care Preparedness and Response Capabilities*, see Appendix 4: Crosswalk of Performance Measures to 2017-2022 Health Care Preparedness and Response Capabilities.

Each HCC will conduct an RCD semiannually to test redundant forms of communication among its members. Redundant communications refers to having multiple back-up communication modalities and is imperative in emergency preparedness planning. Past exercise and real-world event experience demonstrate that health care coalitions cannot depend on just one or even two means for communication.

The following table lists the Data Entity—the organizational level at which the data are captured (awardee or HCC)—and PM type for each PM:

PM	Data Entity	PM Type
12	HCC	Activity
13	HCC	Outcome

Table 14: Section 2 Data Entity and PM Type

The definitions for the PM types are:

- **Activity:** Actions that use or involve HPP inputs; and,
- **Outcome:** Changes or benefits resulting from program activities and outputs. Outcomes can be intended or unintended, positive or negative, and are often divided into short-, intermediate-, and long-term timeframes.

Performance Measure 12

Percent of HCCs that have drilled their redundant communications plans and systems and platforms at least once every six months.

Goal or Target

One hundred percent of HCCs are expected to respond 'Yes' (the HCC has drilled their redundant communications plans and systems and platforms at least once every six months) every budget period.

Operational Intent

Redundant communication systems improve the likelihood that HCCs are able to coordinate response activities during an emergency should one communication system fail. HCCs should test their redundant communication systems using the drill prescribed in the FOA and take corrective action when systems fail. This PM will assess whether regular communications drills are taking place to help ensure that communications plans and systems and platforms are working when needed. The expectation is that each HCC is testing at least one primary and one backup communication system during each drill as detailed in the drill guidance in the FOA.

Data Reporting

Each HCC should report the following data to the awardee. Awardees should report the following data on behalf of each HCC to SHARPER. SHARPER will calculate percentages.

Data Point	Data Entity	Data Source	Response
The HCC has drilled their redundant communications plans and systems and platforms at least once every six months	HCC	Exercise notes or other operational documents	HCC Name:_____ ☐ Yes ☐ No

Table 15: Data Reporting for Performance Measure 12

Definitions and Interpretation

- **Drilled:** Testing at least one primary and one backup communication system as detailed in the drill guidance in the FOA.
- **Redundant communications plans and systems and platforms:** Plans identify reliable, resilient, interoperable, and redundant information and communication systems and platforms by which the HCC intends to send and collect Essential Elements of Information (EEIs). These plans may include incident management software; bed and patient tracking systems; EMS information systems; municipal, hospital, and amateur radio systems; satellite telephones; among others, and are designed to maintain situational awareness during an emergency. Systems and platforms are the tools or methods of sharing EEI to HCC members and other stakeholders.
- **At least once every six months:** The budget period is 12 months. The HCC should plan to conduct at least two RCDs per budget period.

Performance Measure 13

Percent of HCC member organizations that responded during a redundant communications drill by system and platform type used.

Goal or Target

At least two systems and platforms are used in every RCD. SHARPER will establish a baseline based on performance data collected in the first budget period which will be used to set targets and goals for subsequent budget periods.

Operational Intent

Having redundant communication systems improves the likelihood that HCCs 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. However, communications systems—even when functional—have limited value if they are not used by HCC members. This measure will provide insight into the communication process—determining both (a) if communication is occurring between the HCC and its members and (b) which platforms are most widely used during an RCD (see PM 12).

Data Reporting

Each HCC should report the following data to the awardee for each RCD conducted. Awardees should report the following data on behalf of each HCC to SHARPER. Data will be collected for a maximum of one drill each six months. SHARPER will calculate percentages.

Data Point	Data Entity	Data Source	Response
Primary communication system used by the HCC during the drill and number of core and additional member organizations responding	HCC	Drill notes or other operational documents	HCC Name:_____ (Select primary system) ☐ Telephone (landline, fax, Government Emergency Telecommunications Service) ☐ Internet (cable, fiber-optic, VOIP) ☐ Radio (Land Mobile Radio system, amateur, two-way) ☐ Cellular (text, calls, data, pager, Wireless Priority Service) ☐ Satellite (phone, data) (For each member) Member Response: ☐ Yes ☐ No
Backup communication system used by the HCC during the drill and number of core and additional member organizations responding	HCC	Drill notes or other operational documents	(Select backup system) ☐ Telephone (landline, fax, Government Emergency Telecommunications Service) ☐ Internet (cable, fiber-optic, VOIP) ☐ Radio (Land Mobile Radio system, amateur, two-way) ☐ Cellular (text, calls, data, pager, Wireless Priority Service) ☐ Satellite (phone, data) (For each member) Member Response: ☐ Yes ☐ No

Table 16: Data Reporting for Performance Measure 13

Definitions and Interpretation

- **Government Emergency Telecommunications Service:** "Supports national leadership; federal, state, local, tribal and territorial governments; and other authorized national security and emergency preparedness (NS/EP) users. Provides priority access and prioritized processing in the local and long distance segments of the landline networks, greatly increasing the probability of call completion. There is no charge to subscribe to GETS; the only charge for GETS is usage."[7]
- **Land Mobile Radio system:** "Terrestrially-based, wireless communications systems commonly used by federal, state, local, tribal, and territorial emergency responders, public works companies, and even the military to support voice and low-speed data communications. LMR systems typically consist of handheld portable radios, mobile radios, base stations, a network, and repeaters."[8]

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[7] Government Emergency Telecommunications Service (GETS). *Department of Homeland Security.* Accessed 10 Feb, 2017. https://www.dhs.gov/government-emergency-telecommunications-service-gets.

[8] Land Mobile Radio (LMR) 101. *Department of Homeland Security.* Accessed 10 Feb, 2017. https://www.dhs.gov/sites/default/files/publications/LMR%20101_508FINAL.pdf.

- **Responded:** The number of HCC member organizations that have actively confirmed receipt of the HCC's drill communication.
- **Redundant communications drill:** See drill guidance in the FOA.
- **Redundant communications system and platform:** Tools or methods of sharing EEI to HCC members and other stakeholders (e.g., incident management software; bed and patient tracking systems; EMS information systems; municipal, hospital, and amateur radio systems; satellite telephones; among others).

Section 3: Coalition Surge Test Performance Measures

This section contains performance measures (PMs) that use data produced during the annual Coalition Surge Test (CST). These PMs are aligned to the requirements of the *2017-2022 Health Care Preparedness and Response Capabilities* and the FOA. For a crosswalk of PMs to the *2017-2022 Health Care Preparedness and Response Capabilities*, see Appendix 4: Crosswalk of Performance Measures to 2017-2022 Health Care Preparedness and Response Capabilities.

ASPR recognizes that HCCs are diverse and their response capacities may vary. To gauge the full extent of HCC performance, ASPR selected eight PMs to assess the speed and extent to which HCCs can coordinate an evacuation exercise. The eight PMs assess participation and both time- and percent-based outcomes. In aggregate, these eight PMs should enable greater understanding of HCCs' preparedness capacities.

The following table lists the Data Entity—the organizational level at which the data are captured (awardee or HCC)—and PM type for each PM:

PM	Data Entity	PM Type
14	HCC	Output
15	HCC	Output
16	HCC	Outcome
17	HCC	Outcome
18	HCC	Outcome
19	HCC	Outcome
20	HCC	Outcome
21	HCC	Outcome

Table 17: Section 3 Data Entity and PM Type

The definitions for the PM types are:

- **Output:** Products and services produced by HPP activities; and,
- **Outcome:** Changes or benefits resulting from program activities and outputs. Outcomes can be intended or unintended, positive or negative, and are often divided into short-, intermediate-, and long-term timeframes.

Coalition Surge Test

The CST captures information on HCC performance that directly informs the PMs. The CST tests a coalition's ability to work in a coordinated way using their own systems and plans to find appropriate destinations for patients using a simulated evacuation of inpatient facilities that collectively represent at least 20 percent of a coalition's staffed acute care bed capacity. The detailed exercise manual and evaluation tools can be viewed online at http://www.phe.gov/Preparedness/planning/hpp/Pages/coaltion-tool.aspx. In the event that an HCC has a real-world evacuation of at least 20 percent of a coalition's total staffed acute care bed capacity during the reporting year, the HCC can use the data from the real-world evacuation to respond to each applicable PM. The HCC must still submit an AAR/IP that specifically responds to each applicable PM if a real-world evacuation occurs during the reporting year.

The CST includes a low- to no-notice exercise. Low- to no-notice exercising is important in ensuring that HCCs can transition quickly and efficiently into "disaster mode" and provide a more realistic picture of readiness than pre-announced exercises. At least one month in advance, a trusted insider will identify the assessment team and inform HCC members of the two-week window in which the CST will occur. HCC members will not know the exact date and time, and they will not know whether they are playing the role of "evacuating" or "receiving" facility until 60 minutes before the start of the exercise.

The CST is designed to be challenging. Struggling with a challenging exercise may be more helpful in the long run than succeeding with an easier one. Within 90 minutes, an HCC should be able to identify the beds it can make available, determine the patient placements necessary, match patients to those beds, and identify transportation resources appropriate for each patient. While no patients will be moved during the exercise, the actual movement of patients during a real evacuation event may not happen within the 90-minutes of Phase 1 (during the CST, some HCCs may not be able to identify beds and transportation for all patients within 90 minutes).

The CST is intended to improve health care system response readiness. HCCs will select their own peer assessors who can provide exacting, but constructive, feedback to improve response.

The CST tests the overall health care system response. Although the exercise simulates a health facility evacuation, it can reveal preparedness capabilities needed for a number of different scenarios. These capabilities may include emergency operations coordination, information sharing, and medical surge capacity.

The entire CST takes approximately four hours to complete and includes the following phases:

- **Phase 1: Table Top Exercise with Functional Elements and Facilitated Discussion (180-210 minutes)**

  The exercise starts 60 minutes after the assessment team notifies one or more hospitals or other patient-care facilities that they need to stand up their facility command centers. The exercise ends when all patients are placed or after 90 minutes, whichever comes first, after which participants will join a facilitated discussion that explores issues raised during the exercise. The facilitated discussion may include: patient transportation planning, receiving health care facility capacity, patient tracking and public information, the needs of vulnerable patients, and continuity of operations.

- **Phase 2: After Action Review (30-45 minutes)**

  An after action review concludes the CST and consists of an assessment of strengths and weaknesses and corrective action planning. Ideally, this should occur immediately after Phase 1, but **it can be scheduled for a later date** to maximize health care executive participation; however, it must occur within 30 days of Phase 1.

Performance Measure 14

Percent of HCC core member organizations participating in Phase 1: Table Top Exercise with Functional Elements and Facilitated Discussion of the Coalition Surge Test.

Goal or Target

One hundred percent of each HCC's core member organizations are participating in Phase 1 of the CST every budget period.

Operational Intent

Other than actual events, exercises are the primary method for HCCs and their member organizations to demonstrate their ability to perform under emergency scenarios. Therefore, a number of HPP performance indicators are based on exercises. 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.

Data Reporting

Each HCC should report the following data to the awardee. Awardees should report the following data on behalf of each HCC to SHARPER. SHARPER will calculate percentages.

Data Point	Data Entity	Data Source	Response
HCC core member organizations participating in Phase 1: Table Top Exercise with Functional Elements and Facilitated Discussion of the Coalition Surge Test (or real-world evacuation of at least 20 percent of coalition's total beds)	HCC	Attendance log for Phase 1: Table Top Exercise with Functional Elements and Facilitated Discussion of the Coalition Surge Text (or AAR/IP)	HCC Name:_____ For each core member: ☐ Participating ☐ Not Participating

Table 18: Data Reporting for Performance Measure 14

Definitions and Interpretation

- **HCC core member organizations:** Core members are defined in the *2017-2022 Health Care Preparedness and Response Capabilities* as acute care hospitals, EMS, emergency management, and public health. See Appendix 3: List of Core and Additional HCC Member Types for a full list.
- **Participating:** 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.
- **Phase 1: Table Top Exercise with Functional Elements and Facilitated Discussion:** The exercise starts 60 minutes after the assessment team notifies one or more hospitals or other patient-care facilities that they need to stand up their facility command centers. The exercise ends when all patients have an identified bed and mode of transport, or after 90 minutes, whichever comes first. Immediately following the exercise, participants will join a facilitated discussion that explores issues raised during the exercise, which may include: patient transportation planning; receiving health care facility capacity; patient tracking and public information; and, the needs of vulnerable patients and continuity of operations.

- **Coalition Surge Test:** The CST tests a coalition's ability to work in a coordinated way using their own systems and plans to find appropriate destinations for patients using a simulated evacuation of inpatient facilities that collectively represent at least 20 percent of a coalition's staffed acute care bed capacity. The CST is designed to help HCCs identify gaps in their surge planning through a no- or low-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. Further, the test incorporates lessons learned from pilot tests with HCCs in South Dakota, Texas, Michigan, and Wyoming that contributed significantly to the tool's development. The test is available and free for all to use in their health care disaster preparedness and planning. The CST and related materials are available at http://www.phe.gov/Preparedness/planning/hpp/Pages/coaltion-tool.aspx.

- **AAR/IPs:** An After Action Report and Improvement Plan (AAR/IP) is used to provide feedback to participating entities on their performance during an exercise. The AAR/IP summarizes exercise events and analyzes performance of the tasks identified as important during the planning process. It also evaluates achievement of the selected exercise objectives and demonstration of the overall capabilities being validated. The IP portion of the AAR/IP includes corrective actions for improvement, timelines for implementation of corrective actions, and assignment to responsible parties. AAR/IPs should follow Homeland Security Exercise and Evaluation Program (HSEEP) principles and HPP will provide an optional template for future use.[9]

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[9] "Phase 4: After Action Report and Improvement Planning." *City and County of San Francisco Department of Emergency Management*. Accessed 7 Dec. 2016. http://sfdem.org/phase-4-after-action-report-and-improvement-planning-0.

Performance Measure 15

Percent of HCC core member organizations' executives participating in Phase 2: After Action Review of the Coalition Surge Test.

Goal or Target

SHARPER will establish a baseline based on participation of HCCs' core member organizations' executives in Phase 2: After Action Review of the CST in the first budget period which will be used to set targets and goals for subsequent budget periods.

Operational Intent

Member organizations' executive participation 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 indicator 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.

Data Reporting

Each HCC should report the following data to the awardee. Awardees should report the following data on behalf of each HCC to SHARPER. SHARPER will calculate percentages.

Data Point	Data Entity	Data Source	Response
HCC core member organizations' executives participating (in person or virtually) in Phase 2: After Action Review (30-45 minutes) of the Coalition Surge Test (or real-world evacuation of at least 20 percent of coalition's total beds)	HCC	Attendance log for Phase 2: After Action Review of the Coalition Surge Text (or AAR/IP)	HCC Name:_____ For each core member's executive(s): ☐ Participating ☐ Not Participating

Table 19: Data Reporting for Performance Measure 15

Definitions and Interpretation

- **Executives:** An executive is 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. Typical titles of executives with decision-making power include Chief Executive Officer, Chief Operating Officer, Chief Medical Officer, Chief Clinical Officer, Chief Nursing Officer, State and/or Local Director of Public Health, Director of Emergency Management, Administrator on Duty, or Chief of EMS, among others.
- **Participating:** A member organization or executive is considered to be participating if they are physically or remotely connected to the conduct of the After Action Review in real time.
- **Phase 2: After Action Review:** An after action review concludes the exercise and consists of an assessment of strengths and weaknesses and corrective action planning. This phase should be conducted within 30 days of the exercise of the CST.
- **Coalition Surge Test:** The CST tests a coalition's ability to work in a coordinated way using their own systems and plans to find appropriate destinations for patients using a simulated

evacuation of inpatient facilities that collectively represent at least 20 percent of a coalition's staffed acute care bed capacity. The CST is designed to help HCCs identify gaps in their surge planning through a no- or low-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. Further, the test incorporates lessons learned from pilot tests with HCCs in South Dakota, Texas, Michigan, and Wyoming that contributed significantly to the tool's development. The test is available and free for all to use in their health care disaster preparedness and planning. The CST and related materials are available at http://www.phe.gov/Preparedness/planning/hpp/Pages/coaltion-tool.aspx.

- **AAR/IPs:** An After Action Report and Improvement Plan (AAR/IP) is used to provide feedback to participating entities on their performance during an exercise. The AAR/IP summarizes exercise events and analyzes performance of the tasks identified as important during the planning process. It also evaluates achievement of the selected exercise objectives and demonstration of the overall capabilities being validated. The IP portion of the AAR/IP includes corrective actions for improvement, timelines for implementation of corrective actions, and assignment to responsible parties. AAR/IPs should follow Homeland Security Exercise and Evaluation Program (HSEEP) principles and HPP will provide an optional template for future use.[10]

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[10] "Phase 4: After Action Report and Improvement Planning." *City and County of San Francisco Department of Emergency Management*. Accessed 7 Dec. 2016. http://sfdem.org/phase-4-after-action-report-and-improvement-planning-0.

Performance Measure 16

Percent of patients at the evacuating facilities that are identified as able to be: a) discharged safely to home or b) evacuated to receiving facilities during Phase 1: Table Top Exercise with Functional Elements and Facilitated Discussion of the Coalition Surge Test.

Goal or Target

SHARPER will establish a baseline based on performance data collected in the first budget period which will be used to set targets and goals for subsequent budget periods.

Operational Intent

Under a real-world evacuation, it is critical that facilities assess each patient's care needs and determine the most appropriate approach to ensure his/her care and well-being. This indicator will assess HCC member organizations' ability to identify current inpatient needs and decompress. An HCC demonstrates the ability to identify patients able to be evacuated or safely discharged through the successful completion of the CST or real-world evacuation of at least 20 percent of the coalition's baseline of staffed acute care beds. In the exercise, evacuating facilities are instructed to take a current patient count and to work (using whatever communication mechanisms it would during a real evacuation) to find appropriate destinations for each patient.

Data Reporting

Each HCC should report the following data to the awardee. Awardees should report the following data on behalf of each HCC to SHARPER. SHARPER will calculate percentages. All patients at the evacuating facilities shall be represented in one of the data points below.

Data Point	Data Entity	Data Source	Response
Number of patients at evacuating facilities identified as being able to be discharged safely to home during a Coalition Surge Test (or real-world evacuation of at least 20 percent of coalition's beds)	HCC	CST (or AAR/IP)	HCC Name:_____ #_____(Patients)
Number of patients at evacuating facilities identified as being able to be evacuated to receiving facilities during a Coalition Surge Test (or real-world evacuation of at least 20 percent of coalition's beds)	HCC	CST (or AAR/IP)	HCC Name:_____ #_____(Patients)
Total patients at all evacuating facilities at the beginning of the Coalition Surge Test (or real-world evacuation of at least 20 percent of coalition's beds)	HCC	CST (or AAR/IP)	HCC Name:_____ #_____(Patients)

Data Point	Data Entity	Data Source	Response
Total number of staffed acute care beds in the coalition (baseline)	HCC	State licensing data	HCC Name:_____ #_____(Beds)

Table 20: Data Reporting for Performance Measure 16

Definitions and Interpretation

- **Evacuated or discharged safely:** Patients should be categorized by two levels of acuity during the exercise: 1) able to be safely discharged to home or 2) able to be evacuated to receiving facilities based on the patient's clinical status.
- **Home or receiving facilities:** For the purposes of the CST, *no patients will actually be moved*. However, the evacuating facilities, in coordination with their HCC, should identify patients that can be safely discharged or who will need to be evacuated to receiving facilities. Home is the patient's usual and regular living arrangement, such as a barracks, dorm, single-family house, apartment, group home, or other institutional housing. Receiving facilities are all facilities that are able to receive patients. The LEAD Excel tool from the Coalition Surge Tool provides a table for organizing this information.
- **Total patients at evacuating facilities:** The total number of patients at all evacuating facilities participating in Phase 1 of the CST, to include all inpatients in each facility regardless of location or admission status.
- **Total number of staffed acute care beds in the coalition:** HCCs are expected to determine the approximate total number of staffed acute care beds across the coalition in order to identify the evacuating facilities for a CST. The evacuating facilities should collectively represent at least 20 percent of the HCC's total number of staffed acute care beds in order to adequately stress the coalition.
- **Coalition Surge Test:** The CST tests a coalition's ability to work in a coordinated way using their own systems and plans to find appropriate destinations for patients using a simulated evacuation of inpatient facilities that collectively represent at least 20 percent of a coalition's staffed acute care bed capacity. The CST is designed to help HCCs identify gaps in their surge planning through a no- or low-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. Further, the test incorporates lessons learned from pilot tests with HCCs in South Dakota, Texas, Michigan, and Wyoming that contributed significantly to the tool's development. The test is available and free for all to use in their health care disaster preparedness and planning. The CST and related materials are available at http://www.phe.gov/Preparedness/planning/hpp/Pages/coaltion-tool.aspx.
- **AAR/IPs:** An After Action Report and Improvement Plan (AAR/IP) is used to provide feedback to participating entities on their performance during an exercise. The AAR/IP summarizes exercise events and analyzes performance of the tasks identified as important during the planning process. It also evaluates achievement of the selected exercise objectives and demonstration of the overall capabilities being validated. The IP portion of the AAR/IP includes corrective actions for improvement, timelines for implementation of corrective actions, and assignment to responsible parties. AAR/IPs should follow Homeland Security Exercise and Evaluation Program (HSEEP) principles and HPP will provide an optional template for future use.[11]

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[11] "Phase 4: After Action Report and Improvement Planning." *City and County of San Francisco Department of Emergency Management*. Accessed 7 Dec. 2016. http://sfdem.org/phase-4-after-action-report-and-improvement-planning-0.

Performance Measure 17

Time [in minutes] for evacuating facilities in the HCC to report the total number of evacuating patients.

Goal or Target

SHARPER will establish a baseline based on performance data collected in the first budget period which will be used to set targets and goals for subsequent budget periods.

Operational Intent

The CST assesses the preparedness and response performance of HCCs and member organizations across a number of critical functions. While an HCC may have completed foundational aspects of community preparedness (i.e., Preparedness and Response Plans), exercises test an HCC's ability to perform critical functions in an emergency scenario. One of these functions is to identify the total number of patients in an evacuating facility so that receiving facilities may prepare to receive them. This measure determines how quickly evacuating facilities are able to assess and communicate essential patient counts across the HCC.

Data Reporting

Each HCC should report the following data to the awardee. Awardees should report the following data on behalf of each HCC to SHARPER. SHARPER will calculate percentages.

Data Point	Data Entity	Data Source	Response
Time [in minutes] for the last evacuating facility to report the total number of patients identified as able to be evacuated after start of a Coalition Surge Test (or real-world evacuation of at least 20 percent of coalition's total beds)	HCC	CST (or AAR/IP)	HCC Name:_____ 🕐 _____(min) ☐ Not complete in 90 minute Phase 1 exercise

Table 21: Data Reporting for Performance Measure 17

Definitions and Interpretation

- **Time [in minutes]:** Measured from the start of Phase 1 of the CST and ending when the last evacuating facility reports the patient count to be evacuated *or* 90 minutes elapses, whichever is less. If the last evacuating facility cannot report the patient count before 90 minutes elapses, the HCC should indicate 'not complete in 90 minute Phase 1 exercise'.
- **Evacuating facilities:** A trusted insider creates a list of patient care facilities (e.g., hospitals, skilled nursing facilities) that could play the role of evacuating facilities during the exercise. The list should identify backup facilities as well, in case some decline to participate when called, as well as include information on bed and patient count, which might help the assessment team select evacuating facilities. The assessment team (led by the LEAD assessor) will use facility information provided by the trusted insider to identify a facility (or set of facilities) whose evacuation would adequately stress the coalition. Assessors should seek to identify inpatient facilities whose collective evacuation would surge the coalition to 20 percent above staffed acute care bed capacity. The LEAD Excel tool from the Coalition Surge Tool provides a table for organizing this information.

- **Report the total number of patients identified as able to be evacuated:** Evacuating facilities should plan to evacuate all of their patients. Evacuating facilities are instructed to take a current patient count; however, ***there will be no movement of actual patients***. The end point of this measure will be achieved when the last evacuating facility reports their patient count.
- **Coalition Surge Test:** The CST tests a coalition's ability to work in a coordinated way using their own systems and plans to find appropriate destinations for patients using a simulated evacuation of inpatient facilities that collectively represent at least 20 percent of a coalition's staffed acute care bed capacity. The CST is designed to help HCCs identify gaps in their surge planning through a no- or low-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. Further, the test incorporates lessons learned from pilot tests with HCCs in South Dakota, Texas, Michigan, and Wyoming that contributed significantly to the tool's development. The test is available and free for all to use in their health care disaster preparedness and planning. The [CST and related materials](#) are available at http://www.phe.gov/Preparedness/planning/hpp/Pages/coaltion-tool.aspx.
- **AAR/IPs:** An After Action Report and Improvement Plan (AAR/IP) is used to provide feedback to participating entities on their performance during an exercise. The AAR/IP summarizes exercise events and analyzes performance of the tasks identified as important during the planning process. It also evaluates achievement of the selected exercise objectives and demonstration of the overall capabilities being validated. The IP portion of the AAR/IP includes corrective actions for improvement, timelines for implementation of corrective actions, and assignment to responsible parties. AAR/IPs should follow [Homeland Security Exercise and Evaluation Program (HSEEP) principles](#) and HPP will provide an optional template for future use.[12]

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[12] "[Phase 4: After Action Report and Improvement Planning](#)*." City and County of San Francisco Department of Emergency Management*. Accessed 7 Dec. 2016. http://sfdem.org/phase-4-after-action-report-and-improvement-planning-0.

Performance Measure 18

Percent of evacuating patients with an appropriate bed identified at a receiving health care facility in 90 minutes.

Goal or Target

SHARPER will establish a baseline based on performance data collected in the first budget period which will be used to set targets and goals for subsequent budget periods.

Operational Intent

In the CST, HCCs and their member organizations are expected to simulate the assessment of patient acuity at evacuating facilities and identify beds appropriate for patient care needs at receiving facilities. This PM demonstrates the ability of HCCs to load share to meet initial patient care needs under an emergency scenario.

Data Reporting

Each HCC should report the following data to the awardee. Awardees should report the following data on behalf of each HCC to SHARPER. SHARPER will calculate percentages.

Data Point	Data Entity	Data Source	Response
Total beds identified at all receiving facilities at the end of the exercise during a Coalition Surge Test (or real-world evacuation of at least 20 percent of coalition's beds)	HCC	CST (or AAR/IP)	HCC Name:_____ #_____(Beds)
(See PM 16) Number of patients at evacuating facilities identified as being able to be evacuated to receiving facilities during a Coalition Surge Test (or real-world evacuation of at least 20 percent of coalition's beds)	HCC	CST (or AAR/IP)	HCC Name:_____ #_____(Patients)

Table 22: Data Reporting for Performance Measure 18

Definitions and Interpretation

- **Evacuating patients:** Evacuating facilities are instructed to identify all inpatients in each facility regardless of location or admission status and to find appropriate destinations for each patient using whatever communication mechanisms used during a real evacuation. However, *there will be no movement of actual patients.*
- **Appropriate bed identified:** A bed will be considered identified when there is verbal or written (e.g., email or notation in incident management software) agreement from another facility that it can provide an appropriate destination for the patient. Appropriate refers to the clinically appropriate decision based on the patient's specific health care needs.
- **Receiving health care facility:** Potential receiving facilities are all facilities that are able to receive patients, including hospitals and alternate care facilities.
- **Coalition Surge Test:** The CST tests a coalition's ability to work in a coordinated way using their own systems and plans to find appropriate destinations for patients using a simulated

evacuation of inpatient facilities that collectively represent at least 20 percent of a coalition's staffed acute care bed capacity. The CST is designed to help HCCs identify gaps in their surge planning through a no- or low-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. Further, the test incorporates lessons learned from pilot tests with HCCs in South Dakota, Texas, Michigan, and Wyoming that contributed significantly to the tool's development. The test is available and free for all to use in their health care disaster preparedness and planning. The CST and related materials are available at http://www.phe.gov/Preparedness/planning/hpp/Pages/coaltion-tool.aspx.

- **AAR/IPs:** An After Action Report and Improvement Plan (AAR/IP) is used to provide feedback to participating entities on their performance during an exercise. The AAR/IP summarizes exercise events and analyzes performance of the tasks identified as important during the planning process. It also evaluates achievement of the selected exercise objectives and demonstration of the overall capabilities being validated. The IP portion of the AAR/IP includes corrective actions for improvement, timelines for implementation of corrective actions, and assignment to responsible parties. AAR/IPs should follow Homeland Security Exercise and Evaluation Program (HSEEP) principles and HPP will provide an optional template for future use.[13]

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[13] "Phase 4: After Action Report and Improvement Planning." *City and County of San Francisco Department of Emergency Management*. Accessed 7 Dec. 2016. http://sfdem.org/phase-4-after-action-report-and-improvement-planning-0.

Performance Measure 19

Time [in minutes] for receiving facilities in the HCC to report the total number of beds available to receive patients.

Goal or Target

SHARPER will establish a baseline based on performance data collected in the first budget period which will be used to set targets and goals for subsequent budget periods.

Operational Intent

In order to perform its role effectively in an emergency situation, an HCC and its member organizations requires timely access to Essential Elements of Information (EEI). Just as evacuating facilities must communicate the number of patients identified for evacuation, HCCs and their member organizations must know how many beds are available at receiving facilities in order to match them to incoming patients. This measure gauges how quickly receiving facilities are able to assess and communicate EEI across the HCC.

Data Reporting

Each HCC should report the following data to the awardee. Awardees should report the following data on behalf of each HCC to SHARPER. SHARPER will calculate percentages.

Data Point	Data Entity	Data Source	Response
Time [in minutes] for the last receiving facility to report the total number of beds available to receive patients after start of a Coalition Surge Test (or real-world evacuation of at least 20 percent of coalition's total beds)	HCC	CST (or AAR/IP)	HCC Name:_____ 🕐 _____(min) ☐ Not complete in 90 minute Phase 1 exercise

Table 23: Data Reporting for Performance Measure 19

Definitions and Interpretation

- **Time [in minutes]:** Measured from the start of Phase 1 of the CST and ending when the last potential receiving facility reports the number of beds available to receive patients *or* 90 minutes elapses, whichever is less. If the last receiving facility cannot report the number of beds to receive patients before 90 minutes elapses, the HCC should indicate 'not complete in 90 minute Phase 1 exercise'.
- **For the last receiving facility:** Receiving facilities are all facilities that are able to receive patients. The LEAD Excel tool from the Coalition Surge Tool provides a table for organizing this information.
- **Report the total number of beds available to receive patients:** Evacuating facilities are instructed to take a current patient count and to work (using whatever communication mechanisms it would during a real evacuation) to find appropriate destinations for each patient. Appropriate refers to the clinically appropriate decision based on the patient's specific health care needs. A patient will have a bed identified when there is verbal or written (e.g., email or notation in incident management software) agreement from a receiving facility that it can provide an appropriate destination for the patient. However, ***there will be no movement of***

actual patients. The end point of this measure will be achieved when the last potential patient has a bed identified at a receiving facility.

- **Coalition Surge Test:** The CST tests a coalition's ability to work in a coordinated way using their own systems and plans to find appropriate destinations for patients using a simulated evacuation of inpatient facilities that collectively represent at least 20 percent of a coalition's staffed acute care bed capacity. The CST is designed to help HCCs identify gaps in their surge planning through a no- or low-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. Further, the test incorporates lessons learned from pilot tests with HCCs in South Dakota, Texas, Michigan, and Wyoming that contributed significantly to the tool's development. The test is available and free for all to use in their health care disaster preparedness and planning. The CST and related materials are available at http://www.phe.gov/Preparedness/planning/hpp/Pages/coaltion-tool.aspx.

- **AAR/IPs:** An After Action Report and Improvement Plan (AAR/IP) is used to provide feedback to participating entities on their performance during an exercise. The AAR/IP summarizes exercise events and analyzes performance of the tasks identified as important during the planning process. It also evaluates achievement of the selected exercise objectives and demonstration of the overall capabilities being validated. The IP portion of the AAR/IP includes corrective actions for improvement, timelines for implementation of corrective actions, and assignment to responsible parties. AAR/IPs should follow Homeland Security Exercise and Evaluation Program (HSEEP) principles and HPP will provide an optional template for future use.[14]

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[14] "Phase 4: After Action Report and Improvement Planning." *City and County of San Francisco Department of Emergency Management*. Accessed 7 Dec. 2016. http://sfdem.org/phase-4-after-action-report-and-improvement-planning-0.

Performance Measure 20

Percent of evacuating patients with acceptance for transfer to another facility that have an appropriate mode of transport identified in 90 minutes.

Goal or Target

SHARPER will establish a baseline based on performance data collected in the first budget period which will be used to set targets and goals for subsequent budget periods.

Operational Intent

Once appropriate beds are identified by receiving facilities, the HCC and its member organizations will identify the appropriate modes of transport to receiving facilities based on patient care needs. This PM assesses demonstrated ability to meet patient transportation needs.

Data Reporting

Each HCC should report the following data to the awardee. Awardees should report the following data on behalf of each HCC to SHARPER. SHARPER will calculate percentages.

Data Point	Data Entity	Data Source	Response
Total patients matched to a confirmed, appropriate mode of transport to their receiving facility at the end of the exercise (or real-world evacuation of at least 20 percent of coalition's beds)	HCC	CST (or AAR/IP)	HCC Name:_____ #_____(Patients)
(See PM 16) Number of patients at evacuating facilities identified as being able to be evacuated to receiving facilities during a Coalition Surge Test (or real-world evacuation of at least 20 percent of coalition's beds)	HCC	CST (or AAR/IP)	HCC Name:_____ #_____(Patients)

Table 24: Data Reporting for Performance Measure 20

Definitions and Interpretation

- **Evacuating patients:** Evacuating facilities are instructed to identify all inpatients in each facility regardless of location or admission status and to find appropriate destinations and transportation for each patient using whatever communication mechanisms used during a real evacuation. However, ***there will be no movement of actual patients.***
- **Acceptance for transfer to another facility that have a mode of appropriate transport identified:** A patient will be considered accepted for transfer when: 1) there is verbal or written (e.g., email or notation in incident management software) agreement from another facility that it can provide an appropriate destination for the patient; and, 2) the exercise participants have identified appropriate modes of transport that could move patients to their new locations. Appropriate refers to the clinically appropriate decision based on the patient's specific health care needs.

- **Coalition Surge Test:** The CST tests a coalition's ability to work in a coordinated way using their own systems and plans to find appropriate destinations for patients using a simulated evacuation of inpatient facilities that collectively represent at least 20 percent of a coalition's staffed acute care bed capacity. The CST is designed to help HCCs identify gaps in their surge planning through a no- or low-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. Further, the test incorporates lessons learned from pilot tests with HCCs in South Dakota, Texas, Michigan, and Wyoming that contributed significantly to the tool's development. The test is available and free for all to use in their health care disaster preparedness and planning. The CST and related materials are available at http://www.phe.gov/Preparedness/planning/hpp/Pages/coaltion-tool.aspx.
- **AAR/IPs:** An After Action Report and Improvement Plan (AAR/IP) is used to provide feedback to participating entities on their performance during an exercise. The AAR/IP summarizes exercise events and analyzes performance of the tasks identified as important during the planning process. It also evaluates achievement of the selected exercise objectives and demonstration of the overall capabilities being validated. The IP portion of the AAR/IP includes corrective actions for improvement, timelines for implementation of corrective actions, and assignment to responsible parties. AAR/IPs should follow Homeland Security Exercise and Evaluation Program (HSEEP) principles and HPP will provide an optional template for future use.[15]

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[15] "Phase 4: After Action Report and Improvement Planning." *City and County of San Francisco Department of Emergency Management*. Accessed 7 Dec. 2016. http://sfdem.org/phase-4-after-action-report-and-improvement-planning-0.

Performance Measure 21

Time [in minutes] for the HCCs to identify an appropriate mode of transport for the last evacuating patient.

Goal or Target

SHARPER will establish a baseline based on performance data collected in the first budget period which will be used to set targets and goals for subsequent budget periods.

Operational Intent

Once evacuating patients and receiving facility beds have been identified and counted, appropriate modes of transport for patients should be identified. This indicator measures how quickly HCCs can coordinate between EMS, evacuating facilities, other member organizations, and community resources to identify appropriate transport for evacuating patients.

Data Reporting

Each HCC should report the following data to the awardee. Awardees should report the following data on behalf of each HCC to SHARPER. SHARPER will calculate percentages.

Data Point	Data Entity	Data Source	Response
Time [in minutes] for an available and appropriate mode of transport to be identified for the last evacuating patient after start of a Coalition Surge Test (or real-world evacuation of at least 20 percent of coalition's total beds)	HCC	CST (or AAR/IP)	HCC Name:_____ ⊗ _____(min) ☐ Not complete in 90 minute Phase 1 exercise

Table 25: Data Reporting for Performance Measure 21

Definitions and Interpretation

- **Time [in minutes]:** Measured from the start of Phase 1 of the CST and ending when the last evacuating patient has an available and appropriate mode of transport identified _or_ 90 minutes elapses, whichever is less. If an available and appropriate mode of transport is not identified for the last evacuating patient before 90 minutes elapses, the HCC should indicate 'not complete in 90 minute Phase 1 exercise'.
- **Appropriate mode of transport to be identified for the last evacuating patient:** Evacuating facilities are instructed to take a current patient count and to work (using whatever communication mechanisms it would during a real evacuation) to find appropriate destinations and appropriate transport for each patient. Appropriate refers to the clinically appropriate decision based on the patient's specific health care needs. However, *there will be no movement of actual patients.* Evacuating facilities identify appropriate mode(s) of transport that could move patients to their new locations (players are asked to match transportation assets to each individual patient). The LEAD Excel tool from the Coalition Surge Tool provides a table for organizing this information.

- **Coalition Surge Test:** The CST tests a coalition's ability to work in a coordinated way using their own systems and plans to find appropriate destinations for patients using a simulated evacuation of inpatient facilities that collectively represent at least 20 percent of a coalition's staffed acute care bed capacity. The CST is designed to help HCCs identify gaps in their surge planning through a no- or low-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. Further, the test incorporates lessons learned from pilot tests with HCCs in South Dakota, Texas, Michigan, and Wyoming that contributed significantly to the tool's development. The test is available and free for all to use in their health care disaster preparedness and planning. The CST and related materials are available at http://www.phe.gov/Preparedness/planning/hpp/Pages/coaltion-tool.aspx.

- **AAR/IPs:** An After Action Report and Improvement Plan (AAR/IP) is used to provide feedback to participating entities on their performance during an exercise. The AAR/IP summarizes exercise events and analyzes performance of the tasks identified as important during the planning process. It also evaluates achievement of the selected exercise objectives and demonstration of the overall capabilities being validated. The IP portion of the AAR/IP includes corrective actions for improvement, timelines for implementation of corrective actions, and assignment to responsible parties. AAR/IPs should follow Homeland Security Exercise and Evaluation Program (HSEEP) principles and HPP will provide an optional template for future use.[16]

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[16] "Phase 4: After Action Report and Improvement Planning." *City and County of San Francisco Department of Emergency Management*. Accessed 7 Dec. 2016. http://sfdem.org/phase-4-after-action-report-and-improvement-planning-0.

Section 4: Joint Performance Measures

This section contains joint performance measures (PMs) between HPP and the Emergency Medical Services for Children (EMSC) and the Public Health Emergency Preparedness (PHEP) programs. These PMs are aligned to the requirements of the *2017-2022 Health Care Preparedness and Response Capabilities* and the FOA. For a crosswalk of PMs to the *2017-2022 Health Care Preparedness and Response Capabilities*, see Appendix 4: Crosswalk of Performance Measures to 2017-2022 Health Care Preparedness and Response Capabilities.

Awardees and HCCs will not report data on these PMs to HPP. EMSC and PHEP will collect this information as part of their grants and cooperative agreements, and share the data with HPP and SHARPER.

The following table lists the Data Entity—the organizational level at which the data are captured (awardee or HCC)—and PM type for each PM:

PM	Data Entity	PM Type
22	Hospital	Activity
J.1	Awardee	Outcome
J.2	Awardee	Outcome

Table 26: Section 4 Data Entity and PM Type

The definitions for the PM types are:

- **Activity:** Actions that use or involve HPP inputs; and,
- **Outcome:** Changes or benefits resulting from program activities and outputs. Outcomes can be intended or unintended, positive or negative, and are often divided into short-, intermediate, and long-term timeframes.

Performance Measure 22

Percent of hospitals with an Emergency Department (ED) recognized through a statewide, territorial, or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies.

Goal or Target

Determined by Emergency Medical Services for Children (EMSC).

Operational Intent

Determine if hospitals have EDs that are recognized through a statewide, territorial, or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies. HPP will review overall trends in HCCs with hospitals capable of stabilizing and managing a pediatric patient. The inclusion of this measure links the HPP and Emergency Medical Services for Children (EMSC) programs: highlighting pediatric readiness as key to ensuring states are considering the special needs of children during emergencies.

Data Reporting

As the data on this joint measure is collected by EMSC as part of their grant requirements, no data will be collected by HPP**.**

Data Point	Data Entity	Data Source	Response
Reported by EMSC: Hospitals with Emergency Departments that are able to stabilize and/or manage pediatric medical emergencies provided by EMSC	Hospitals	EMSC[17]	n/a

Table 27: Data Reporting for Performance Measure 22

Definitions and Interpretation

- **Emergency Medical Services for Children (EMSC):** EMSC grants have helped all 50 states, the District of Columbia, and five U.S. territories and freely associated states (the Commonwealth of the Northern Mariana Islands, American Samoa, the U.S. Virgin Islands, Guam, and Puerto Rico). Grant funds have improved the availability of child-appropriate equipment in ambulances and emergency departments; supported hundreds of programs to prevent injuries; and provided thousands of hours of training to emergency medical technicians, paramedics, and other emergency medical care providers. The EMSC Program supported legislation mandating EMSC initiatives in several states, and to educational materials covering every aspect of pediatric emergency care. Most importantly, EMSC efforts are saving kids' lives.

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[17] No data collection required. EMSC will provide the data on the hospitals with EDs that are able to stabilize and/or manage pediatric medical emergencies. HPP awardees, HCCs, and hospitals do not need to provide any data to HPP for this component of the measure.

Performance Measure HPP-PHEP J.1: Information Sharing

Percentage of local partners that requested Essential Elements of Information (EEI) to the public health/medical lead within the awardee's timeframe.

Awardees are required to report twice for this measure. If you have zero or one data point to report, conduct exercises (including drills) or planned events to obtain two data points for this PM. Only information sharing related to an MCM incident or scenario (including an exercise or drill) will count towards the MCM ORR, so ensure this is accomplished at least every other year. In alternate years, consider exercising information sharing related to non-MCM incidents and scenarios to test capability for sharing different types of EEI with different local partners.

How is the measure calculated?

Numerator: Number of local partners that reported requested EEI to the public health/medical lead within the requested timeframe

Denominator: Number of local partners that received a request for EEI

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 public health/medical lead in order to facilitate situational awareness and the effective management of resources in a timely manner.

What other requirements are there for reporting measure data?

This measure requires submission of self-reported data. Data should be collected and reported by incident (or planned event or exercise). *Awardees are required to report at least two data points for this measure.* One data point must reflect the awardee's best performance (highest percentage); the other must reflect performance which, based on a determination from the awardee, calls for focused quality improvement and, if applicable, technical assistance. Awardees are encouraged to submit data on additional incidents, planned events and exercises as well. There are no specific reporting requirements or parameters for these additional data points.

How does this measure align with the MCM ORR tool?

Information sharing is essential during responses to all emergencies, and is particularly important to the facilitation of situational awareness and appropriate allocation of resources during an MCM incident. The MCM ORR tool requires exercising the sharing of EEI every two years during an MCM-related incident. There is an opportunity to work with partners to align EEI sharing processes for the HPP-PHEP J.1 and the MCM ORR by conducting an MCM-oriented exercise or drill every two years and on alternate years conducting an exercise or drill to share EEI for other hazards. Data from HPP-PHEP J.1 will apply directly to the MCM ORR.

What data must be reported?

1. Number of local partners that received a request for EEI (denominator) [Max five digits]
2. Number of local partners that reported requested EEI to the health and medical lead within the requested timeframe (numerator) [Max five digits]
    Performance Measure: Percent of local partners that reported EEI to the health/medical lead within the requested timeframe (System calculated) *[Percentage]*

3. The request for EEI occurred during a/an: *[Select one]*
   - Incident
   - Full scale exercise
   - Functional exercise
   - Drill
   - Planned event

4. Please identify the type of incident/exercise/planned event upon which the request for EEI was based.* *[Select only one, even if multiple hazards existed in one incident]*
   - Extreme weather (e.g., heat wave, ice storm)
   - Flooding
   - Earthquake
   - Hurricane/tropical storm
   - Hazardous material
   - Fire
   - Tornado
   - Biological hazard or disease, please specify *[Max 100 characters]*
   - Radiation
   - Other, please specify *[Max 100 characters]*

5. Was this incident/exercise/planned event MCM-related? New – check to align with MCM ORR
   - Yes
   - No

6. Please provide the name and date of the incident/planned event/exercise.
   - Name *[Max 100 characters]*
   - Date *[MM/DD/YYYY]*

7. This incident/planned event/exercise utilized or demonstrated one or more functions within the *[Select one]*
   - HPP Capability
   - PHEP Capability
   - Both HPP and PHEP Capabilities

8. Please state how many of each type(s) of local partners responded to the request.
   [Max five digits for each type]
   - Hospitals
   - Long-term care facilities
   - Community health center
   - Healthcare Organizations (HCOs)
   - Local public health entities

9. Did "other" types of local partners (not listed above) respond to the request?
   [Maximum five "other" types]
   - Yes
   - No
     - Please describe other type #1. *[Max 100 characters]*
     - How many local partners of "other" type #1 responded to the request?[Max three digits]
     - Please describe other type #2. *[Max 100 characters]*

- How many local partners of other type #2 responded to the request? *[Max three digits]*
- Please describe other type #3. *[Max 100 characters]*
- How many local partners of other type #3 responded to the request*? [Max three digits]*
- Please describe other type #4. *[Max 100 characters]*
- How many local partners of "other" type #4 responded to the request? *[Max three digits]*
- Please describe other type #5. *[Max 100 characters]*
- How many local partners of "other" type #5 responded to the request? *[Max three digits]*

10. Please identify the requesting entity (e.g., public health/medical lead at the state, sub-state regional or local level). *[Select one]*
    - State health/medical lead (or designee)
    - Sub-state regional health/medical lead (or designee)
    - Local health/medical lead (or designee)
    - Other, please specify [Max 100 characters]

11. Please identify the types of EEI requested. *[Select all that apply]*
    - Facility operating status
    - Facility structural integrity
    - The status of evacuations/shelter in-place operations
    - Status of critical medical services (e.g., trauma, critical care)
    - Critical service/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/mass vaccine sites data (e.g. throughout, open/set-up status, etc.),
    - Other, please specify [Max 100 characters]

12. Please identify the type of IT or other communication system used to request EEI from local partners. *[Select all that apply]*
    - Telecommunication (e.g., cell phone, satellite phone, landline)
    - E-mail
    - Online/web interface (electronic bed or patient tracking, survey tools, WebEOC or similar, etc.)
    - Health Alert Network
    - Other, please specify [Max 100 characters]

13. Continuous Quality Improvement:
    - Were relevant corrective actions/improvement plans items from prior responses (including exercises, drills, etc.) related to information sharing incorporated into planning and/or response procedures before this incident/drill took place?
        - Yes
        - No
        - Some

- Have corrective actions/improvement plan items related to information sharing been identified as a result of this incident/drill?
  - Yes
  - No
- Have they been implemented?
  - Yes
  - No
  - Some

14. Please indicate any barriers to submitting requested EEI within the requested timeframe. *[Select all that apply]*
    - Communication
    - Equipment
    - Funding
    - Participation
    - Policies/procedures
    - Resource limitations
    - Staffing
    - Time constraints
    - Training
    - Other, please specify
    - None

15. *[Optional]* Please provide any additional clarifying, contextual, or other information
    [Max 1,000 characters]

How is this measure operationalized?

This measure intends to capture information on the communication of incident-specific public health/medical EEIs. Determination of which EEIs are to be requested or collected during a response, as well as which local entities should report the information and the timeframe in which the information should be reported, should be based on established plans, protocols and procedures, but are ultimately at the discretion of the incident commander or designee.

If large volumes of EEI are collected in an incident, it is the responsibility of the awardee to determine which of this information was "essential"—and therefore able to count towards the numerator and denominator—for this PM.

Key Measurement Terms

Essential Elements of Information (EEI): Essential elements of information are discrete types of reportable public health or healthcare-related incident-specific knowledge communicated or received concerning a particular fact or circumstance, preferably reported in a standardized manner or format, which assists in generating situational awareness for decision-making purposes. EEI are often coordinated and agreed upon pre-incident (and communicated to local partners) as part of information collection request templates and emergency response playbooks.

Local partners: Local partners are entities, at the local level, which receive requests for EEI. Local partners may differ based on the type of incident/exercise/planned event (e.g., HCOs, LHDs, healthcare coalitions.

Requested timeframe: Requested timeframe is an awardee-defined period of time for receiving requested EEI (e.g., operational period, set time to meet special request, e.g., 1500 hours).

Responsible entity or entities: A responsible entity or entities refers to an organization at the awardee or sub-awardee level, which is accountable for completing the specific activity or element associated with one or more PHEP PMs.

Performance Measure HPP-PHEP J.2: Volunteer Management

Percentage of volunteers deployed to support a public health/medical incident within the requested timeframe.

How is the measure calculated?

Numerator: Number of volunteers, determined to be needed for the response by the public health/medical lead or other authorized official that arrived on scene (including staging area or other designated area) within the requested timeframe

Denominator: Number of volunteers determined to be needed for the response by the public health/medical lead or other authorized official

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 public health/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 health care organizations.

What other requirements are there for reporting measure data?

- Awardees may report the numerator and denominator of this measure *by incident or exercise* at the state, sub-state regional or local level.
- **Awardees that experience two or more incidents or exercises** involving deployment of volunteers **must report on at least** two of those.
  - One data point must reflect the awardee's best performance (highest percentage);
  - The other data point must reflect performance that, based on a determination from the awardee, calls for focused quality improvement and – if applicable – technical assistance.
  - Awardees are encouraged to submit data on additional incidents and exercises as well. There are no specific reporting requirements or parameters for additional data points.
- *Awardees that experience only one incident or exercise* involving deployment of volunteers must report on it.
- *Awardees that experience no incidents or exercises* involving deployment of volunteers do not need to report on this measure; however, they must conduct a call down and acknowledgement drill. The call down and acknowledgement drill contains the following required data elements:
  - Number of volunteers contacted (registered in the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) system)
  - Number of volunteer contacted (registered in other systems)
  - Number of volunteers in the ESAR-VHP system that acknowledged contact within the requested timeframe
  - Number of volunteers registered in other systems that acknowledged contact within

> the requested timeframe
>> ▪ The requested timeframe for acknowledgment (e.g., four hours, eight hours, 12 hours, etc.)
>> ▪ Date of call down drill

- The call down and acknowledgement drill, above, may *not* be reported in lieu of PM HPP-PHEP J.2, if there occurred incidents or exercises involving actual deployment of volunteers in the budget period.
- In future budget periods, awardees may be required to exercise actual volunteer deployment if there are no volunteer deployments during a public health/medical incident in consecutive budget periods.

How does this measure align with the MCM ORR tool?

While there are no direct links between HPP-PHEP J.2 and the MCM ORR, there are various activities related to volunteer management that are applicable to both.

What data must be reported?

1. This PM is required if an incident/exercise involving the management of volunteers occurred within the past budget period. Did an incident/exercise involving the deployment of volunteers occur?
   - Yes
   - No *[If no, only Question 15 is required]*

For each incident or exercise reported for demonstration of the Volunteer Management Capability, please enter the following information:

2. The number of volunteers determined to be needed for the response by the public health/medical lead or other authorized official (denominator)

3. The number of volunteers who arrived at staging area/on scene within the requested timeframe (numerator) *[Max five digits].* Of these:
   - Number of deployed volunteers registered in ESAR-VHP *[Max five digits]*
   - Number of deployed volunteers registered in other systems *[Max five digits]*

   Total *[Max five digits] [System Calculated] (Note: Sum of 3a and 3b must equal value entered for Question 3.)*
   Percentage of volunteers deployed to support a public health/medical incident within an appropriate timeframe. *[System Calculated]*
   (PM for HPP/PHEP – J.2)

4. Requested timeframe for on-scene (including staging area or other designated area) arrival of volunteers *[Max 100 characters]*

5. The request for volunteers occurred during a(n): *[Select one]*
   - Incident
   - Full Scale Exercise
   - Functional Exercise
   - Drill

6. This incident or exercise utilized or demonstrated one or more functions within the:
   [Select one]
   - HPP Volunteer Management Capability
   - PHEP Volunteer Management Capability
   - Both HPP and PHEP Volunteer Management Capabilities

7. The name and date of the incident or exercise. Name *[Max 100 characters]*
   Date *[MM/DD/YYYY]*

8. The type of incident or exercise upon which the request for volunteers was based: *[Select only one, even if multiple hazards existed in one incident]*
   - Extreme weather (e.g., heat wave, ice storm)
   - Flooding
   - Earthquake
   - Hurricane/tropical storm
   - Hazardous material
   - Fire
   - Tornado
   - Biological hazard or disease - Please specify *[Max 100 characters]*
   - Radiation
   - Other (Please Specify) *[Max 100 characters]*

9. The entity that made the original request for volunteers *[Select one]*
   - Local health department
   - State health department
   - Healthcare organization
   - Healthcare coalition
   - Other, please specify: *[Max 100 characters]*

10. The requested location for the deployment *[Select one]*
    - Staging/assembly area(s) (not actual incident site)
    - Hospital(s)
    - Shelter(s)
    - Points of Dispensing (POD or PODs)
    - Alternate care site(s), please specify *[Max 750 characters]*
    - Other, please specify *[Max 100 characters]*

11. The number of volunteers who were contacted for potential deployment *[Max five digits]*

12. Please indicate any barriers to deploying volunteer to support a public health/medical incident within requested timeframe. *[Select all that apply]*
    - Communication
    - Equipment
    - Funding
    - Participation
    - Policies/procedures
    - Resource limitations
    - Staffing
    - Time constraints
    - Training
    - Other, please specify
    - None

13. Continuous Quality Improvement:
    - Were relevant corrective actions/improvement plans items from prior responses (including exercises, drills, etc.) related to volunteer management incorporated into planning and/or

response procedures before this incident/drill took place?
- ▪ Yes
- ▪ No
- ▪ Some
- Have corrective actions/improvement plan items related to volunteer management been identified as a result of this incident/drill?
  - ▪ Yes
  - ▪ No
- Have they been implemented?
  - ▪ Yes
  - ▪ No
  - ▪ Some

14. [Optional] Please provide any additional clarifying, contextual, or other information
- *[Max 1,000 characters]*

15. Awardees that experience no incidents or exercises involving deployment of volunteers do not need to report on this measure; however they must conduct a call down and acknowledgement drill. Please enter the following information on the call down drill.
- Number of volunteers contacted (registered in the ESAR-VHP system) *[Max five digits]*
- Number of volunteers contacted (registered in other systems) *[Max five digits]*
- Number of volunteers in the ESAR-VHP system that acknowledged contact within the requested timeframe *[Max five digits]*
- Number of volunteers registered in other systems that acknowledged contact within the requested timeframe *[Max five digits]*
- Requested timeframe for acknowledgment: Hours/Minutes

How is this measure operationalized?

The numerator and denominator for this measure should refer to aggregate numbers of volunteers across a given incident. For example, the public health/medical lead determines in Week 1 of an incident that 100 volunteers are needed.

In Week 2 it is determined that an additional 100 volunteers are needed. The denominator for this incident is 200.

Awardees should ensure that the number of volunteers included in the denominator does *not* refer to the total number of *potential* volunteers that have been contacted to determine deployment availability or "requested" to deploy. It should only refer to the number of volunteers that the public health/medical lead has determined are needed for the response and has requested for the incident. This number may or may not coincide with how many have been "requested" to deploy via a call down or activation, and should be independent of how many are known to be available. For example, the public health/medical lead determines that 75 volunteers are needed on-scene within three days.

She makes this request to the state volunteer coordinator, who contacts 900 individuals currently in the ESAR-VHP database. After contacting the entire database of potential volunteers, the volunteer coordinator informs the public health/medical lead that only 20 are available for deployment. The public health/medical lead agrees to take however many are available. Twenty volunteers arrive at the staging area within the three day timeframe. The numerator for this incident is 20. The denominator is 75. The denominator is *not* 20 even though the public health/medical lead "agrees" that 20 is acceptable, since this number did not reflect true need, but rather was a function of how many volunteers were available

for deployment. Similarly, the denominator is not 900 since this number simply reflects how many individuals were contacted for potential deployment

Key Measurement Terms

Deploy: Deployment is defined as the movement of activated volunteers to a staging area or assigned mission location such as the scene of an incident, planned event, or exercise.

Out-processing volunteers: Out-processing volunteers refers to the return of equipment, operational debriefing, and any transfer of command or responsibilities.

Request: A request is a formal application to ask for a specified number of needed volunteers, typically by local response entities, to the health and medical lead at the local, regional or state level.

Requested timeframe: Requested timeframe is the period of time in which volunteers are requested to report for duty.

Responsible entity or entities: A responsible entity or entities refers to an organization at the awardee or sub-awardee level, which is accountable for completing the specific activity or element associated with one or more PHEP PMs.

Tracking volunteers: Tracking volunteers refers to the process, plans, or procedures to capture volunteer activities, roles, locations, etc.

Volunteers: Volunteers are individuals supporting the public health/medical incident, including medical and non-medical professionals (e.g., from the ESAR-VHP system, Medical Reserve Corps, etc.)

Section 5: Select U.S. Territories and Freely Associated States Performance Measures

This section only applies to the U.S. Territories of American Samoa, Commonwealth of Northern Marianas, and U.S. Virgin Islands, and the Freely Associated States of Federated States of Micronesia, Republic of Palau, and Republic of the Marshall Islands. The U.S. Territories of Guam and Puerto Rico are not included in this category and shall report on all performance measures (PMs) except 23 to 28.

Please refer to the section Overview of Performance Measures for Select U.S. Territories and Freely Associated States for guidance on measures in other sections of this document that are relevant to these select U.S. Territories and Freely Associated States. For a crosswalk of PMs to the *2017-2022 Health Care Preparedness and Response Capabilities*, see Appendix 4: Crosswalk of Performance Measures to 2017-2022 Health Care Preparedness and Response Capabilities.

ASPR recognizes that awardees and HCCs in the select U.S. Territories and Freely Associated States are diverse and their response capacities may vary. To gauge the full extent of HCC performance, ASPR selected six PMs to assess the extent to which HCCs can coordinate a medical surge exercise. The six PMs assess participation and percent-based outcomes. In aggregate, these six PMs should enable greater understanding of preparedness capacities in the select U.S. Territories and Freely Associated States.

The following table lists the Data Entity—the organizational level at which the data are captured (awardee or HCC)—and PM type for each PM:

PM	Data Entity	PM Type
23	Hospital	Output
24	Hospital	Output
25	Hospital	Outcome
26	Hospital	Outcome
27	Hospital	Outcome
28	Hospital	Outcome

Table 28: Section 5 Data Entity and PM Type

The definitions for the PM types are:
- **Output:** Products and services produced by HPP activities; and,
- **Outcome:** Changes or benefits resulting from program activities and outputs. Outcomes can be intended or unintended, positive or negative, and are often divided into short-, intermediate, and long-term timeframes.

Hospital Surge Test

The HST will only be annually required for the select U.S. Territories and Freely Associated States. 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. Hospitals need to exercise their preparedness for a mass

casualty incident regularly. The HST can help hospital emergency managers to make recurring table top exercises a reality by providing a fully developed table top exercise that can be used at their facilities. The HST has two components, one for triaging patients in the emergency department (ED) and another for the hospital incident command center.

Emergency Department Table Top Exercise Component

The ED component requires that the players in the exercise, typically a nurse and physician, be free of clinical duties and able to take instructions from the Command Center during the course of the exercise. They will be asked to triage the auto-generated list of patients who are presenting. The ED must be able to communicate with the hospital's Command Center.

Command Center Table Top Exercise Component

The command center component requires incident command leadership and necessary staff to respond and to assess capabilities such as bed availability within the facility. Both the command center and ED components of an exercise are run concurrently.

Expected Outcomes

At the conclusion of the exercise there will be an after action review to discuss a variety of quantitative and qualitative metrics. The after action review includes feedback from the two areas of activity for the exercise, the ED and Command Center. This is supported by graphical displays of data that are automatically generated using the data collected throughout the exercise. These data displays, which can be projected on screen and saved for future use, include:

- Immediate Bed Availability Over Time
- Patients Arrivals Over Time (By Criticality Type)
- Patient Transfers Out of the ED Over Time

Staff Commitments & Time Requirements

In order for the exercise to be successful, four peer assessors, preferably from another health care entity, are required. Two will be positioned in the ED at the start of the exercise (with their laptops) and applicable exercise software; two will be positioned in the Hospitals' Command Center with their laptops and applicable software.

The peer assessor roles are:

- The ED Controller
- The ED Qualitative Evaluator
- The Incident Command (Command Center) Evaluator
- The Bed Control Evaluator

As mentioned above in the ED Table Top Exercise Component section, two ED staff, typically a doctor and a nurse, **free of other clinical duties** for the duration of the actual exercise (75 to 90 minutes) need to be on hand. These ED staff will triage the automated generated list of patients who are presenting. The command center component requires incident command leadership and necessary staff to respond and to assess capabilities such as bed availability within the facility.

HPP estimates that it will take two to three hours for the exercise director to become familiar with the HST materials. The HST should take between 90 minutes to two hours to complete. The exercise scenarios can be modified and customized by incident type, patient load and treatment requirements. Additional time (approximately one to two hours) is also necessary for an after action review with the peer assessors as described above.

The current version of the HST incorporates lessons learned from pilot tests with a number of hospitals during the second half of 2014. To learn more about the HST and how it works, see the HST at http://www.phe.gov/Preparedness/planning/hpp/surge/Pages/default.aspx. For additional questions or to discuss this tool further please contact your HPP FPO.

Performance Measure 23

Percent of HCC core member organizations participating in the Command Center Table Top and Emergency Department Table Top during the Hospital Surge Test.

Goal or Target

One hundred percent of each HCC's core member organizations are participating in the Command Center Table Top and Emergency Department Table Top during the HST every budget period.

Operational Intent

Other than actual events, exercises are the primary method for HCCs and their member organizations to demonstrate their ability to perform under emergency scenarios. Therefore, a number of HPP performance indicators are based on exercises. 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.

Data Reporting

Each HCC should report the following data to the awardee. Awardees should report the following data on behalf of each HCC to SHARPER. SHARPER will calculate percentages.

Data Point	Data Entity	Data Source	Response
HCC core member organizations participating in the Command Center Table Top and Emergency Department Table Top of the Hospital Surge Test	HCC	Attendance log for the Command Center Table Top and Emergency Department Table Top of the HST	For each core member: ☐ Participating ☐ Not Participating

Table 29: Data Reporting for Performance Measure 23

Definitions and Interpretation

- **Participating:** A member organization is considered to be participating if they are physically or remotely connected to the conduct of the exercise in real time.
- **Command Center Table Top:** The command center component requires incident command leadership and necessary staff to respond and to assess capabilities such as bed availability within the facility. These may also be referred to as "players." Both the Command Center and Emergency Department components of an exercise are run concurrently.
- **Emergency Department Table Top:** The ED component requires that the "players" in the exercise, typically a nurse and physician, be free of clinical duties and able to take instructions from the Command Center "players" during the course of the exercise. They will be asked to triage the automated generated list of patients who are presenting. The ED must be able to communicate with the hospital's Command Center.
- **Hospital Surge Test:** 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 exercise is a low- to no-notice exercise, and incorporates the real-life considerations of healthcare delivery in acute care settings. The exercise is intended for use by hospital emergency managers, hospital administrators, and clinical staff to assess and improve their hospital's surge plans. Hospitals need to exercise their preparedness for a mass casualty incident regularly. This exercise can help

hospital emergency managers to make recurring table top exercises a reality by providing a fully developed table top exercise that can be used at their facilities.

Performance Measure 24

Percent of HCC core member organizations' executives participating in the After Action Review of the Hospital Surge Test.

Goal or Target

SHARPER will establish a baseline based on participation of HCCs' core member organizations' executives in the After Action Review of the HST in the first budget period which will be used to set targets and goals for subsequent budget periods.

Operational Intent

Participation of member organizations' executives demonstrates an HCC's ability to perform its role as a convener. Executive-level participation in the After Action Review phase of the HST increases the likelihood that HCC member organizations can act on lessons learned, improving preparedness and response capabilities for their communities. This indicator 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.

Data Reporting

Each HCC should report the following data to the awardee. Awardees should report the following data on behalf of each HCC to SHARPER. SHARPER will calculate percentages.

Data Point	Data Entity	Data Source	Response
HCC core member organizations' executives participating (in person or virtually) in the After Action Review of the Hospital Surge Test	HCC	Attendance log for the After Action Review of the HST	For each core member's executive(s): ☐ Participating ☐ Not Participating

Table 30: Data Reporting for Performance Measure 24

Definitions and Interpretation

- **Executives:** An executive is 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. Typical titles of executives with decision-making power include Chief Executive Officer, Chief Operating Officer, Chief Medical Officer, Chief Clinical Officer, Chief Nursing Officer, State and/or Local Director of Public Health, Director of Emergency Management, Administrator on Duty, or Chief of EMS, among others.
- **Participating:** A member organization or executive is considered to be participating if they are physically or remotely connected to the After Action Review in real time.
- **After Action Review:** An after action review concludes the exercise and consists of an assessment of strengths and weaknesses and corrective action planning. This phase should be conducted within 30 days of the exercise of the HST.

- **Hospital Surge Test:** 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 exercise is a low- to no-notice exercise, and incorporates the real-life considerations of healthcare delivery in acute care settings. The exercise is intended for use by hospital emergency managers, hospital administrators, and clinical staff to assess and improve their hospital's surge plans. Hospitals need to exercise their preparedness for a mass casualty incident regularly. This exercise can help hospital emergency managers to make recurring table top exercises a reality by providing a fully developed table top exercise that can be used at their facilities.

Performance Measure 25

Percentage of ICU beds made available during the Hospital Surge Test.

Goal or Target

SHARPER will establish a baseline based on performance data collected in the first budget period which will be used to set targets and goals for subsequent budget periods.

Operational Intent

In the HST, HCCs and their member organizations are expected to simulate a surge of patients into the emergency department and identify appropriate destinations based on patient care needs. This PM demonstrates the ability of HCCs to increase bed availability in the ICU to meet initial patient care needs.

Data Reporting

Awardees should report the following data to SHARPER. SHARPER will calculate percentages.

Data Point	Data Entity	Data Source	Response
Number of empty staffed ICU beds	Hospital	HST	#_____(Beds)
Number of ICU Patients (Red) Admitted from the ED	Hospital	HST	#_____(Patients)
Number of ICU Patients (Red) Transferred Out or Discharged	Hospital	HST	#_____(Patients)
Number of New ICU Treatment Spaces	Hospital	HST	#_____(Beds)
Number of total (empty or occupied) staffed ICU beds	Hospital	HST	#_____(Beds)

Table 31: Data Reporting for Performance Measure 25

Definitions and Interpretation

- **Hospital Surge Test:** 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 exercise is a low- to no-notice exercise, and incorporates the real-life considerations of healthcare delivery in acute care settings. The exercise is intended for use by hospital emergency managers, hospital administrators, and clinical staff to assess and improve their hospital's surge plans. Hospitals need to exercise their preparedness for a mass casualty incident regularly. This exercise can help hospital emergency managers to make recurring table top exercises a reality by providing a fully developed table top exercise that can be used at their facilities.
- **Treatment Spaces:** Treatment space refers to any space the hospital or facility designates as a space to render emergency care.[18]

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[18] Welch, S., et al., "Setting up a Quality Improvement Program for your ED." *Health Administration Press*. 2011.

Performance Measure 26

Percentage of non-ICU beds made available during the Hospital Surge Test.

Goal or Target

SHARPER will establish a baseline based on performance data collected in the first budget period which will be used to set targets and goals for subsequent budget periods.

Operational Intent

In the HST, HCCs and their member organizations are expected to simulate a surge of patients into the emergency department and identify appropriate destinations based on patient care needs. This PM demonstrates the ability of HCCs to increase bed availability on the floor to meet initial patient care needs.

Data Reporting

Awardees should report the following data to SHARPER. SHARPER will calculate percentages.

Data Point	Data Entity	Data Source	Response
Number of empty staffed non-ICU beds	Hospital	HST	#_____(Beds)
Number of non-ICU Patients (Yellow) Admitted from the ED	Hospital	HST	#_____(Patients)
Number of non-ICU Patients (Yellow) Transferred Out or Discharged	Hospital	HST	#_____(Patients)
Number of new non-ICU Treatment Spaces	Hospital	HST	#_____(Beds)
Number of total (empty or occupied) staffed adult medical/surgical (non-ICU) beds	Hospital	HST	#_____(Beds)

Table 32: Data Reporting for Performance Measure 26

Definitions and Interpretation

- **Hospital Surge Test:** 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 exercise is a low- to no-notice exercise, and incorporates the real-life considerations of healthcare delivery in acute care settings. The exercise is intended for use by hospital emergency managers, hospital administrators, and clinical staff to assess and improve their hospital's surge plans. Hospitals need to exercise their preparedness for a mass casualty incident regularly. This exercise can help hospital emergency managers to make recurring table top exercises a reality by providing a fully developed table top exercise that can be used at their facilities.
- **Treatment Spaces:** Treatment space refers to any space the hospital or facility designates as a space to render emergency care.[19]

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[19] Welch, S., et al., "Setting up a Quality Improvement Program for your ED." *Health Administration Press*. 2011.

Performance Measure 27

Percentage of emergency department beds made available during the Hospital Surge Test.

Goal or Target

SHARPER will establish a baseline based on performance data collected in the first budget period which will be used to set targets and goals for subsequent budget periods.

Operational Intent

In the HST, HCCs and their member organizations are expected to simulate a surge of patients into the emergency department and identify appropriate destinations based on patient care needs. This PM demonstrates the ability of HCCs to increase bed availability in the emergency department to meet initial patient care needs.

Data Reporting

Awardees should report the following data to SHARPER. SHARPER will calculate percentages.

Data Point	Data Entity	Data Source	Response
Number of regular treatment beds in the main part of the ED at the end of the exercise	Hospital	HST	#_____(Beds)
Number of regular treatment beds in the main part of the ED at the beginning of the exercise	Hospital	HST	#_____(Beds)

Table 33: Data Reporting for Performance Measure 27

Definitions and Interpretation

- **Hospital Surge Test:** 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 exercise is a low- to no-notice exercise, and incorporates the real-life considerations of healthcare delivery in acute care settings. The exercise is intended for use by hospital emergency managers, hospital administrators, and clinical staff to assess and improve their hospital's surge plans. Hospitals need to exercise their preparedness for a mass casualty incident regularly. This exercise can help hospital emergency managers to make recurring table top exercises a reality by providing a fully developed table top exercise that can be used at their facilities.

Performance Measure 28

Percentage of patients with a bed identified in the emergency department during the [Hospital Surge Test](#).

Goal or Target

SHARPER will establish a baseline based on performance data collected in the first budget period which will be used to set targets and goals for subsequent budget periods.

Operational Intent

In the HST, HCCs and their member organizations are expected to simulate a surge of patients into the emergency department and identify appropriate destinations based on patient care needs. This PM demonstrates the ability of HCCs to increase bed availability in the emergency department to meet initial patient care needs.

Data Reporting

Awardees should report the following data to SHARPER. SHARPER will calculate percentages.

Data Point	Data Entity	Data Source	Response
Number of total regular treatment beds in the main part of the ED at the end of the exercise	Hospital	[HST](#)	#_____(Beds)
Number of total emergent (Red) and urgent (Yellow) patients at the end of the exercise	Hospital	[HST](#)	#_____(Patients)

Table 34: Data Reporting for Performance Measure 28

Definitions and Interpretation

- **Hospital Surge Test:** 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 exercise is a low- to no-notice exercise, and incorporates the real-life considerations of healthcare delivery in acute care settings. The exercise is intended for use by hospital emergency managers, hospital administrators, and clinical staff to assess and improve their hospital's surge plans. Hospitals need to exercise their preparedness for a mass casualty incident regularly. This exercise can help hospital emergency managers to make recurring table top exercises a reality by providing a fully developed table top exercise that can be used at their facilities.

Glossary

Term	Definition
Access and Functional Needs	Access-based needs: All people must have access to certain resources, such as social services, accommodations, information, transportation, medications to maintain health, and so on. Function-based needs: Function-based needs refer to restrictions or limitations an individual may have that requires assistance before, during, and/or after a disaster or public health emergency.[20]
Acute Care Hospitals	A hospital that provides inpatient medical care and other related services for surgery, acute medical conditions or injuries (usually for a short term illness or condition).
After Action Report and Improvement Plan	An After Action Report and Improvement Plan (AAR/IP) is used to provide feedback to participating entities on their performance during an exercise. The AAR/IP summarizes exercise events and analyzes performance of the tasks identified as important during the planning process. It also evaluates achievement of the selected exercise objectives and demonstration of the overall capabilities being validated. The IP portion of the AAR/IP includes corrective actions for improvement, timelines for implementation of corrective actions, and assignment to responsible parties. AAR/IPs should follow Homeland Security Exercise and Evaluation Program (HSEEP) principles and HPP will provide an optional template for future use.[21]

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[20] "At Risk Individuals." *Public Health Emergency*, 8 Sept. 2016. Web. Accessed 16 Sept. 2016. http://www.phe.gov/ Preparedness/planning/abc/Pages/atrisk.aspx.

[21] "Phase 4: After Action Report and Improvement Planning*." City and County of San Francisco Department of Emergency Management*. Accessed 7 Dec. 2016. http://sfdem.org/phase-4-after-action-report-and-improvement-planning-0.

Term	Definition
Census/Social Vulnerability Index	The Social Vulnerability Index can be accessed at http://svi.cdc.gov/map.aspx. The index contains information on 14 population variables with access and functional needs drawn from the Census and American Community Survey. The Census data is updated every decade and the American Community Survey is updated annually. The SVI provides an estimate of the access and functional needs in a community across four domains derived from the Census and the American Community Survey: Socioeconomic status (below the poverty line; unemployed; low income; adults without a high school diploma), Household Composition & Disability (elderly; children; civilian with a Disability; single parent households), Minority Status & Language (minority households and speak English 'less than well'), and Housing & Transportation (individuals in group homes; high density housing; mobile homes; high density households; and households without vehicles).
Coalition Surge Test	The CST tests a coalition's ability to work in a coordinated way using their own systems and plans to find appropriate destinations for patients using a simulated evacuation of inpatient facilities that collectively represent at least 20 percent of a coalition's staffed acute care bed capacity. The CST is designed to help HCCs identify gaps in their surge planning through a no- or low-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. Further, the test incorporates lessons learned from pilot tests with HCCs in South Dakota, Texas, Michigan, and Wyoming that contributed significantly to the tool's development. The test is available and free for all to use in their health care disaster preparedness and planning. The CST and related materials are available at http://www.phe.gov/Preparedness/planning/hpp/Pages/coaltion-tool.aspx.
Critical Care	Critical care helps people with life-threatening injuries and illnesses. It might treat problems such as complications from surgery, accidents, infections, and severe breathing problems. It involves close, constant attention by a team of specially-trained health care providers. Critical care usually takes place in an intensive care unit (ICU) or trauma center.[22]
Data Entity	For each PM, the organization(s) providing the data for the measure (awardee, HCC, or hospital) is listed.

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[22] "Critical Care." *MedlinePlus,* 2 Apr. 2015. Web. Accessed 16 Sept. 2016. medlineplus.gov/criticalcare.html.

Term	Definition
Data Points	For each PM, the individual data points that must be reported to calculate the PM, including the data entity, data source, and response.
Data Source	For each PM, documentation or systems where PM data is documented and managed (e.g., exercise materials, meeting notes, or financial statements). Data sources should be archived for future verification purposes.
Definitions and Interpretations	For each PM, specific language is linked to a detailed definition for each PM. These definitions and interpretations provide guidance on how to interpret key terms and phrases within the context of the PM.
Disaster	A hazard impact causing adverse physical, social, psychological, economic or political effects that challenges the ability to rapidly and effectively respond. Despite a stepped-up capacity and capability (call-back procedures, mutual aid, etc.) and change from routine management methods to an incident command/management process, the outcome is lower than expected compared with a smaller scale or lower magnitude impact (See "emergency" for important contrast between the two terms).[23]
Emergency	A hazard impact causing adverse physical, social, psychological, economic or political effects that challenges the ability to rapidly and effectively respond. It requires a stepped-up capacity and capability (call-back procedures, mutual aid, etc.) to meet the expected outcome, and commonly requires change from routine management methods to an incident command process to achieve the expected outcome (See "disaster" for important contrast between the two terms).[24]

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[23] "ICDRM/GWU Emergency Management Glossary of Terms." *The George Washington University Institute for Crisis, Disaster, and Risk Management,* 30 Jun. 2010. pp. 30. PDF. Accessed 19 Jul. 2016. www.gwu.edu/~icdrm/publications/PDF/GLOSSARY - Emergency Management ICDRM 30 JUNE 10.pdf.

[24] "ICDRM/GWU Emergency Management Glossary of Terms." *The George Washington University Institute for Crisis, Disaster, and Risk Management,* 30 Jun. 2010. pp. 32. PDF. Accessed 19 Jul. 2016. www.gwu.edu/~icdrm/publications/PDF/GLOSSARY - Emergency Management ICDRM 30 JUNE 10.pdf.

Term	Definition
Emergency Medical Services for Children (EMSC)	EMSC cooperative agreements have helped all 50 states, the District of Columbia, and five U.S. territories (the Commonwealth of the Northern Mariana Islands, American Samoa, the U.S. Virgin Islands, Guam, and Puerto Rico). Cooperative agreement funds have improved the availability of child-appropriate equipment in ambulances and emergency departments; supported hundreds of programs to prevent injuries; and provided thousands of hours of training to emergency medical technicians, paramedics, and other emergency medical care providers. The EMSC Program supported legislation mandating EMSC initiatives in several states, and to educational materials covering every aspect of pediatric emergency care. Most importantly, EMSC efforts are saving kids' lives. The EMSC program is administered by the Health Resources and Services Administration.
Emergency Operations Center (EOC)	The physical location at which the coordination of information and resources to support incident management (on-scene operations) activities normally takes place. An EOC may be a temporary facility or may be located in a more central or permanently established facility, perhaps at a higher level of organization within a jurisdiction. EOCs may be organized by major functional disciplines (e.g., fire, law enforcement, medical services), by jurisdiction (e.g., federal, state, regional, tribal, city, county), or by some combination thereof.[25]
Emergency Operations Plan (EOP)	The "response plan" that an entity (organization, jurisdiction, state, etc.) maintains that describes intended response to any emergency situation. It provides action guidance for management and emergency response personnel during the response phase.[26]
Emergency Support Function-8 (ESF-8) – Public Health and Medical Services Annex	ESF-8 (Public Health and Medical Services) provides the mechanism for coordinated federal assistance to supplement state, tribal, and local resources in response to the following: • Public health and medical care needs • Veterinary and/or animal health issues in coordination with the U.S. Department of Agriculture (USDA) • Potential or actual incidents of national significance • A developing potential health and medical situation[27]

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[25] Ibid., 34.

[26] Ibid.

[27] "Emergency Support Functions" *Public Health Emergency,* 2 Jun. 2015. Web. Accessed 12 Sept. 2016. http://www.phe.gov/Preparedness/support/esf8/Pages/default.aspx#8.

Term	Definition
ESF-8 lead agency	ESF-8 language distinguishes between lead and supporting agencies to conduct an emergency response.[28] Within the context of Emergency Support Functions (ESF), primary agencies have significant authorities, roles, resources, and capabilities for a particular function within an ESF.
Essential Elements of Information (EEI)	Information collected under the Emergency Support Functions (ESF) to enable situational awareness of an incident or response.[29]
Goal or Target	Ideal or recommended result or achievement based on baseline data, benchmarks, or program requirements, and can be set using a formula or a benchmark. In some cases, this section indicates that the goal or target may be set at a later date after data from the first budget period has been reviewed.
Health Care Coalition(s) (HCC)	A group of individual health care and response organizations (e.g., hospitals, emergency medical services (EMS), emergency management organizations, public health agencies, etc.) in a defined geographic location. HCCs play a critical role in developing health care delivery system preparedness and response capabilities. HCCs serve as multiagency coordinating groups that support and integrate with ESF-8 activities in the context of incident command system (ICS) responsibilities.
Health Care Coalition (HCC) Member	An HCC member is defined as an entity within the HCC's defined boundaries that actively contributes to HCC strategic planning, operational planning and response, information sharing, and resource coordination and management.
Health Care Facility	Any asset where point-of-service medical care is regularly provided or provided during an incident. It includes hospitals, integrated health care systems, private physician offices, outpatient clinics, long-term care, and other medical care configurations. During an emergency response, alternative medical care facilities and sites where definitive medical care is provided by emergency medical services (EMS) and other field personnel would be included in this definition.[30]

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[28] "Emergency Support Functions." *ASPR,* 2 Jun. 2015. Web. Accessed 7 Dec. 2016. http://www.phe.gov/Preparedness/support/esf8/Pages/default.aspx#eme.

[29] "Essential Elements of Information." Public Health Emergency, 13 Aug. 2012. Web. Accessed 16 Sept. 2016. www.phe.gov/Preparedness/planning/playbooks/rdd/Pages/essentialelements.aspx.

[30] "ICDRM/GWU Emergency Management Glossary of Terms." The George Washington University Institute for Crisis, Disaster, and Risk Management, 30 Jun. 2010. pp. 48. PDF. Accessed 19 Jul. 2016. www.gwu.edu/~icdrm/publications/PDF/GLOSSARY - Emergency Management ICDRM 30 JUNE 10.pdf.

Term	Definition
Hospital Surge Test	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 exercise is a low- to no-notice exercise, and incorporates the real-life considerations of healthcare delivery in acute care settings. The exercise is intended for use by hospital emergency managers, hospital administrators, and clinical staff to assess and improve their hospital's surge plans. Hospitals need to exercise their preparedness for a mass casualty incident regularly. This exercise can help hospital emergency managers to make recurring table top exercises a reality by providing a fully developed table top exercise that can be used at their facilities.
Immediate Bed Availability (IBA)	The ability of a hospital to provide no less than 20 percent bed availability of staffed beds within four hours of a disaster. It is built on three pillars: continuous monitoring across the health system; off-loading of patients who are at low risk for untoward events through reverse triage; and on-loading of patients from the disaster.[31]
Incident Command System (ICS)	A systematic, proactive approach to guide departments and agencies at all levels of government, nongovernmental organizations, and the private sector to work together seamlessly and manage incidents involving all threats and hazards—regardless of cause, size, location, or complexity—in order to reduce loss of life, property and harm to the environment.[32]
In-kind support	**In-kind support from sources other than the awardee:** Any non-monetary support for HCC activities received from sources other than the awardee. For further definitions of in-kind support, see [45 Code of Federal Regulation (CFR), Part 92.24](#) available at https://www.gpo.gov/fdsys/pkg/CFR-2005-title45-vol1/pdf/CFR-2005-title45-vol1-sec92-24.pdf. • **Physical space:** For example, meeting space, exercise space, offices, storage, etc. • **Equipment/Supplies:** For example, communication or office equipment, or administrative supplies. • **Services:** For example, printing, logistical, transportation, accounting, or administrative services. • **Labor Hours:** For example, labor hours of HCC coordinator or other HCC members working on HCC-related activities, if the individual is a volunteer or employed by a member organization.

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[31] Hick, John L., et al. "[Health Care Facility and Community Strategies for Patient Care Surge Capacity](#)." *Annals of Emergency Medicine.* 15 Jul. 2004. PDF. Accessed 15 Sept. 2016. http://www.aha.org/content/00-10/Hick.pdf.

[32] "[The National Incident Management System.](#)" *FEMA,* 28 Jun. 2016. Web. Accessed 22 Sept. 2016. http://www.fema.gov/national-incident-management-system.

Term	Definition
Jurisdictional Risk Assessment	Awardees are required to coordinate the completion of JRAs to identify potential hazards, vulnerabilities, and risks within the community, including interjurisdictional (e.g., cross-border) risks as appropriate, that specifically relate to the public health, medical, and mental/behavioral systems and the functional needs of at-risk individuals.
Member Type	A category of health care coalition (HCC) members that represents a type of facility or organization (e.g., all nursing facilities, all hospitals, or all emergency medical services (EMS) agencies within one HCC).
Operational Intent	A brief description of the purpose of each PM and its link to preparedness program priorities.
Population with Access and Functional Needs	**Access-based needs**: All people must have access to certain resources, such as social services, accommodations, information, transportation, medications to maintain health, and so on. **Function-based needs**: Function-based needs refer to restrictions or limitations an individual may have that requires assistance before, during, and/or after a disaster or public health emergency.
Preparedness Plan	A Preparedness Plan meets the required components identified in the FOA. This includes information collected on hazard vulnerabilities and risks, resources, gaps, needs, and legal and regulatory considerations. The HCC Preparedness Plan enhances preparedness and risk mitigation through cooperative activities based on common priorities and objectives.
Response	For each PM, the format for reporting on the required data points of the associated PM.
Response Plan	A Response Plan meets the required components identified in the FOA. An HCC Response Plan describes HCC operations that support strategic planning, information sharing, and resource management. The plan also describes the integration of these functions with the ESF-8 lead agency to ensure information is provided to local officials and to effectively communicate and address resource and other needs requiring ESF-8 assistance.
Treatment Spaces	Treatment space refers to any space the hospital or facility designates as a space to render emergency care.
Whole Community	A means by which residents, emergency management practitioners, organizational and community leaders, and government officials can collectively understand and assess the needs of their respective communities and determine the best ways to organize and strengthen their assets, capacities, and interests.[33]

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[33] "Whole Community." *FEMA*, 10 Jun. 2016. Web. Accessed 20 Jul. 2016. www.fema.gov/whole-community.

Appendix 1: CDC-RFA-TP17-1701 Logic Model: HPP-PHEP Cooperative Agreement

Figure 1: HPP-PHEP Cooperative Agreement Logic Model
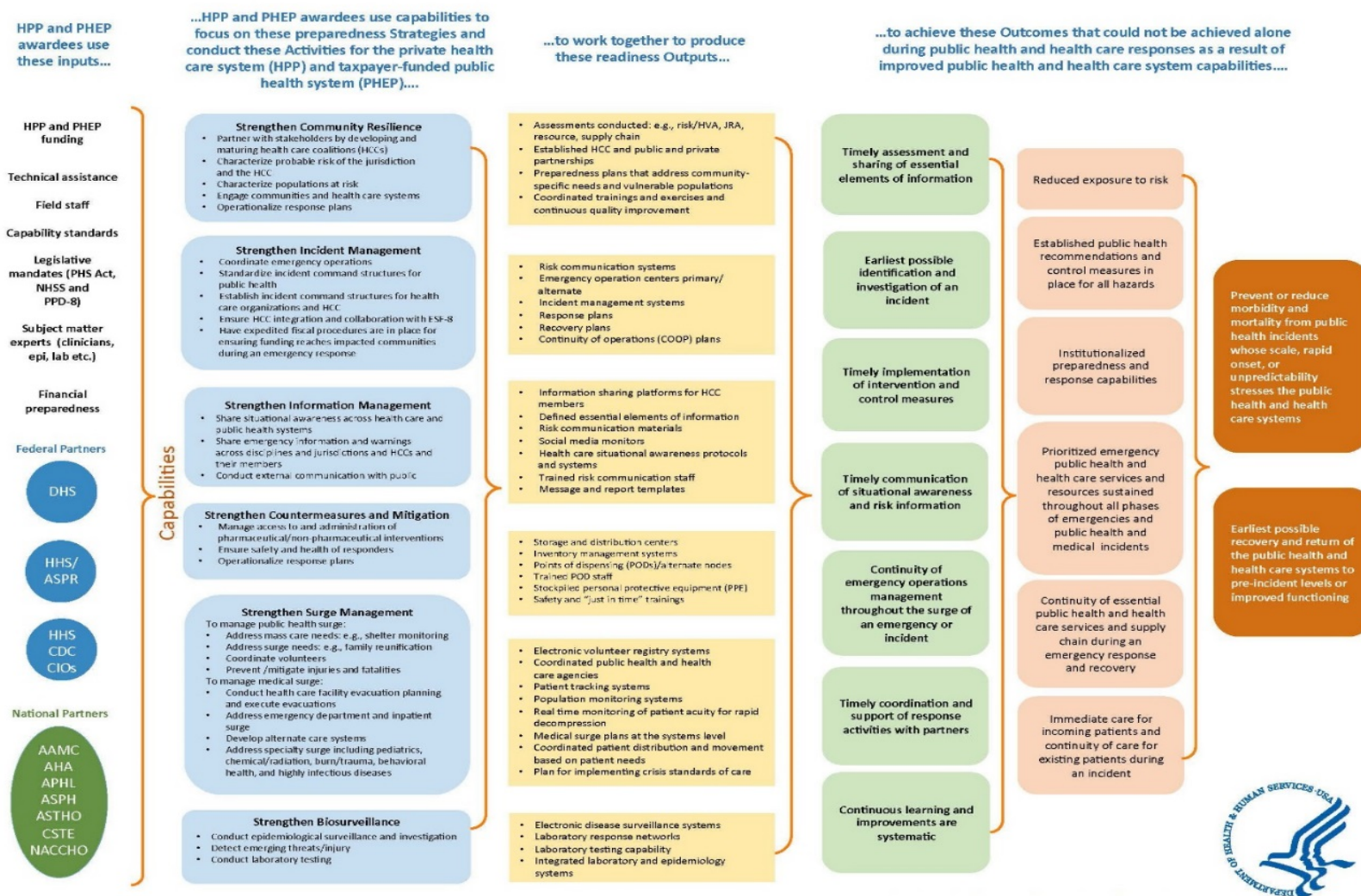
This logic model is detailed on page 10 of the 2017-2022 Hospital Preparedness Program (HPP) - Public Health Emergency Preparedness (PHEP) Cooperative Agreement CDC-RFA-TP17-1701.

Appendix 2: The 2017-2022 HPP Performance Measures Development Process

The 2017-2022 HPP PMs were developed based on guidance provided in the *2017-2022 Health Care Preparedness and Response Capabilities* and the FOA. The PMs were developed with several principles in mind:

- Balance measures considering different audiences and information needs, including national-level (Congress, HHS, Partners), program-level (HPP, FPOs), and implementation-level (awardees, HCCs, and facilities);
- Align with revised *2017-2022 Health Care Preparedness and Response Capabilities;*
- Consider burden to awardees and HCCs;
- Develop measures that are objective and exercise-based;
- Build upon foundational achievements from previous project period funding cycles; and,
- Signal program priorities with measures.

SHARPER incorporated the lessons learned from previous responses to emergencies, literature on program evaluations, and extensive stakeholder engagement. A literature review and environmental scan were conducted to inform measures development. The following stakeholders and partners were engaged directly or indirectly: SHARPER and HPP FPOs; awardees and HCCs; the ASPR At-Risk Individuals, Behavioral Health & Community Resilience (ABC) division; congressional and press inquiries; and external partner working groups.

SHARPER engaged the NHPP division, awardees and HCCs, and subject matter experts to develop the program's theory of change and these PMs. NHPP conducted a division-wide facilitated workshop to design the program's theory of change, defining the short, medium, and long-term outcomes of the health care system. Using the theory of change as a guiding framework for both capabilities and measures development, SHARPER identified every measureable concept in the capabilities for which HCCs are responsible and HPP intends to invest. Next, SHARPER streamlined the draft measures to reflect burden considerations and other guiding principles. SHARPER engaged awardees, HCCs, and national partners, in a burden and feasibility review through a period of open comment. Based on feedback from national engagement, SHARPER refined the measures for inclusion in the FOA. Finally, to support the implementation of the PMs, SHARPER developed this implementation guide and piloted the guide with a small number of awardees and HCCs recruited to provide detailed feedback on guidance language.

Appendix 3: List of Core and Additional HCC Member Types

HCC members are delineated in the *2017-2022 Health Care Preparedness and Response Capabilities.*

- Core HCC members must include, at a minimum, the following:
    - Two Acute Care Hospitals
    - EMS (including inter-facility and other non-EMS patient transport systems)
    - Emergency management organizations
    - Public health agencies
- Additional HCC members include, but are not limited to, the following:
    - Hospitals and behavioral health services and organizations
    - Community Emergency Response Team[34] and Medical Reserve Corps[35]
    - Dialysis centers and regional Centers for Medicare & Medicaid Services (CMS)-funded end-stage renal disease networks[36]
    - Federal facilities (e.g., U.S. Department of Veterans Affairs Medical Centers, Indian Health Service facilities, military treatment facilities)
    - Home health agencies (including home and community-based services)
    - Infrastructure companies (e.g., utility and communication companies)
    - Jurisdictional partners, including cities, counties, and tribes
    - Local chapters of health care professional organizations (e.g., medical society, professional society, hospital association)
    - Local public safety agencies (e.g., law enforcement and fire services)
    - Medical and device manufacturers and distributors
    - Non-governmental organizations (e.g., American Red Cross, voluntary organizations active in disaster, amateur radio operators, etc.)
    - Outpatient health care delivery (e.g., ambulatory care, clinics, community and tribal health centers, Federally Qualified Health Centers[37], urgent care centers, free standing emergency rooms, stand-alone surgery centers)
    - Primary care providers, including pediatric and women's health care providers
    - Public or private payers (e.g., Medicare and insurance companies)
    - Schools and universities, including academic medical centers
    - Skilled nursing, nursing, and long-term care facilities
    - Support service providers (e.g., clinical laboratories, pharmacies, radiology, blood banks, poison control centers)
    - Other (e.g., child care services, dental clinics, social work services, faith-based organizations)

Specialty patient referral centers (e.g., pediatric, burn, trauma, and psychiatric centers) should be HCC members within their geographic boundaries. They may also serve as referral centers to other HCCs

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[34] "Community Emergency Response Teams." *FEMA*, 31 Aug. 2016. Web. Accessed 7 Sept. 2016. www.fema.gov/community-emergency-response-teams/.

[35] "About the Medical Reserve Corps." *MRC,* 22 Sept. 2016. Web. Accessed 26 Sept. 2016. https://mrc.hhs.gov.

[36] "End-Stage Renal Disease Networks." *KCER*, 2016. Web. Accessed 7 Sept. 2016. http://kcercoalition.com/en/esrd-networks/.

[37] "What are Federally qualified health centers?" HRSA, n.d. Web. Accessed 7 Sept. 2016. www.hrsa.gov/healthit/toolbox/ RuralHealthITtoolbox/Introduction/qualified.html.

where that specialty care does not exist. In such cases, referral centers' support of HCC planning, exercises, and response activities can be mutually beneficial.

Urban and rural HCCs may have different membership compositions based on population characteristics, geography, and types of hazards. For example, in rural and frontier areas—where the distance between hospitals may exceed 50 miles and where the next closest hospitals are also critical access hospitals with limited services—tribal health centers, referral centers, or support services may play a more prominent role in the HCC.

Appendix 4: Crosswalk of Performance Measures to 2017-2022 Health Care Preparedness and Response Capabilities

Table 36: Crosswalk of PM to the capability, objective, and activity in the *2017-2022 Health Care Preparedness and Response Capabilities.*

PM Description	Capability
PM1: Percent of funding each HCC receives from the awardee, other federal sources, and non-federal sources.	• Capability 1 – Foundation for Health Care and Medical Readiness ▪ Objective 5 – Ensure Preparedness is Sustainable ➢ Activity 5 – Promote Sustainability of Health Care Coalitions
PM2: Number of calendar days from start of budget period for awardees to execute subawards with each HCC.	• Capability 1 – Foundation for Health Care and Medical Readiness

PM3: Membership representation rate of HCC core (acute care Hospitals, EMS, Emergency Management, Public Health) and additional member organizations by member type.	• Capability 1 – Foundation for Health Care and Medical Readiness
	 ▪ Objective 1 – Establish and Operationalize a Health Care
	  ➢ Activity 1 – Define Health Care Coalition Boundaries
	  ➢ Activity 2 – Identify Health Care Coalition Members

PM4: Percent of HCCs that have a complete and approved Preparedness Plan.	• Capability 1 – Foundation for Health Care and Medical Readiness
	 ▪ Objective 2 – Identify Risk and Needs
	  ➢ Activity 2 – Assess Regional Health Care Resources
	  ➢ Activity 3 – Prioritize Resource Gaps and Mitigation Strategies
	 ▪ Objective 3 – Develop a Health Care Coalition Preparedness Plan

PM5: Percent of HCCs that have a complete and approved Response Plan.	• Capability 2 – Health Care and Medical Response Coordination ▪ Objective 1 – Develop and Coordinate Health Care Organization and Health Care Coalition Response Plans ➢ Activity 2 – Develop a Health Care Coalition Response Plan

PM Description	Capability

PM6, Part A: Percent of awardees that obtain de-identified data from emPOWER at least once every six months to identify numbers of individuals with electricity-dependent medical and assistive equipment for planning purposes.
 	
PM6, Part B: Percent of HCCs that obtain de-identified data from emPOWER at least once every six months to identify numbers of individuals with electricity-dependent medical and assistive equipment for planning purposes.
	• Capability 1 – Foundation for Health Care and Medical Readiness
	   ▪ Objective 2 – Identify Risk and Needs
	      ➢ Activity 4 – Assess Community Planning for Children, Pregnant Women, Seniors, Individuals with Access and Functional Needs, Including People with Disabilities, and Others with Unique Needs

PM7, Part A: Percent of awardees that obtain data from the Social Vulnerability Index to estimate the populations with a higher likelihood of having access and functional needs for planning purposes at least once per year.
 	
PM7, Part B: Percent of HCCs that obtain data from the Social Vulnerability Index to estimate the populations with a higher likelihood of having access and functional needs for planning purposes at least once per year.
	• Capability 1 – Foundation for Health Care and Medical Readiness
	   ▪ Objective 2 – Identify Risk and Needs
	      ➢ Activity 4 – Assess Community Planning for Children, Pregnant Women, Seniors, Individuals with Access and Functional Needs, Including People with Disabilities, and Others with Unique Needs

PM8: Percent of awardees that have provided an opportunity for each HCC to review and provide input to the awardee's ESF-8 preparedness and response plan.	• Capability 1 – Foundation for Health Care and Medical Readiness
	   ▪ Objective 1 – Establish and Operationalize a Health Care
	      ➢ Activity 3 – Establish Health Care Coalition Governance

PM Description	Capability

PM9: Percent of HCCs engaged in their awardee's jurisdictional risk assessment.	• Capability 1 – Foundation for Health Care and Medical Readiness
	  ▪ Objective 2 – Identify Risk and Needs
	    ➢ Activity 1 – Assess Hazard Vulnerabilities and Risks

PM10: Percent of HCCs where areas for improvement have been identified from HCC and member organizations' own exercises or real-world events and the HCCs' preparedness and response plans have been revised to reflect improvements.	• Capability 1 – Foundation for Health Care and Medical Readiness
	  ▪ Objective 4 – Train and Prepare the Health Care and Medical Workforce
	    ➢ Activity 5 – Evaluate Exercises and Responses to Emergencies
	    ➢ Activity 6 – Share Leading Practices and Lessons Learned

PM11: Percent of awardees with a complete, jurisdiction-wide protocol that delineates a) the appropriate allocation of scarce resources during crises and b) local and regional crisis standards of care (CSC) planning and implementation efforts.	• Capability 1 – Foundation for Health Care and Medical Readiness
	  ▪ Objective 2 – Identify Risk and Needs
	    ➢ Activity 5 – Assess and Identify Regulatory Compliance Requirements
	• Capability 2 – Health Care and Medical Response Coordination
	  ▪ Objective 1 – Develop and Coordinate Health Care Organization and Health Care Coalition Response Plans
	    ➢ Activity 2 – Develop a Health Care Coalition Response Plan

PM12: Percent of HCCs that have drilled their redundant communications plans and systems and platforms at least once every six months.	• Capability 2 – Health Care and Medical Response Coordination
	  ▪ Objective 2 – Utilize Information Sharing Procedures and Platforms
	    ➢ Activity 1 – Develop Information Sharing Procedures

PM13: Percent of HCC member organizations that responded during a redundant communications drill by system and platform type used.	• Capability 2 – Health Care and Medical Response Coordination
	  ▪ Objective 2 – Utilize Information Sharing Procedures and Platforms
	    ➢ Activity 3 – Utilize Communications Systems and Platforms

PM14: Percent of HCC core member organizations participating in Phase 1: Table Top Exercise with Functional Elements and Facilitated Discussion of the Coalition Surge Test.	• Capability 1 – Foundation for Health Care and Medical Readiness
	  ▪ Objective 1 – Establish and Operationalize a Health Care
	    ➢ Activity 2 – Identify Health Care Coalition Members
	    ➢ Activity 3 – Establish Health Care Coalition Governance
	  ▪ Objective 4 – Train and Prepare the Health Care and Medical Workforce
	    ➢ Activity 3 – Plan and Conduct Coordinated Exercises with Health Care Coalition Members

PM Description	Capability
PM15: Percent of HCC core member organizations' executives participating in Phase 2: After Action Review of the Coalition Surge Test.	• Capability 1 – Foundation for Health Care and Medical Readiness ▪ Objective 5 – Ensure Preparedness is Sustainable ➢ Activity 2 – Engage Health Care Executives
PM16: Percent of patients at the evacuating facilities that are identified as able to be: a) discharged safely to home or b) evacuated to receiving facilities during Phase 1: Table Top Exercise with Functional Elements and Facilitated Discussion of the Coalition Surge Test.	• Capability 3 – Continuity of Health Care Service Delivery ▪ Objective 6 – Plan for and Coordinate Health Care Evacuation and Relocation ➢ Activity 1 – Develop and Implement Evacuation and Relocation Plans • Capability 4 – Medical Surge ▪ Objective 2 – Respond to a Medical Surge ➢ Activity 1 – Implement Emergency Department and Inpatient Medical Surge Response
PM17: Time [in minutes] for evacuating facilities in the HCC to report the total number of evacuating patients.	• Capability 2 – Health Care and Medical Response Coordination ▪ Objective 1 – Develop and Coordinate Health Care Organization and Health Care Coalition Response Plans ➢ Activity 2 – Develop a Health Care Coalition Response Plan ▪ Objective 3 – Coordinate Response Strategy, Resources, and Communications ➢ Activity 1 – Identify and Coordinate Resource Needs during an Emergency • Capability 3 – Continuity of Health Care Service Delivery ▪ Objective 6 – Plan for and Coordinate Health Care Evacuation and Relocation ➢ Activity 1 – Develop and Implement Evacuation and Relocation Plans
PM18: Percent of evacuating patients with an appropriate bed identified at a receiving health care facility in 90 minutes.	• Capability 3 – Continuity of Health Care Service Delivery ▪ Objective 6 – Plan for and Coordinate Health Care Evacuation and Relocation ➢ Activity 1 – Develop and Implement Evacuation and Relocation Plans • Capability 4 – Medical Surge ▪ Objective 2 – Respond to a Medical Surge ➢ Activity 1 – Implement Emergency Department and Inpatient Medical Surge Response

PM Description	Capability

PM19: Time [in minutes] for receiving facilities in the HCC to report the total number of beds available to receive patients.	• Capability 2 – Health Care and Medical Response Coordination
	   ▪ Objective 1 – Develop and Coordinate Health Care Organization and Health Care Coalition Response Plans
	      ➢ Activity 2 – Develop a Health Care Coalition Response Plan
	   ▪ Objective 3 – Coordinate Response Strategy, Resources, and Communications
	      ➢ Activity 1 – Identify and Coordinate Resource Needs during an Emergency
	• Capability 3 – Continuity of Health Care Service Delivery
	   ▪ Objective 6 – Plan for and Coordinate Health Care Evacuation and Relocation
	      ➢ Activity 1 – Develop and Implement Evacuation and Relocation Plans
	• Capability 4 – Medical Surge
	   ▪ Objective 2 – Respond to a Medical Surge
	      ➢ Activity 1 – Implement Emergency Department and Inpatient Medical Surge Response

PM20: Percent of evacuating patients with acceptance for transfer to another facility that have an appropriate mode of transport identified in 90 minutes.	• Capability 3 – Continuity of Health Care Service Delivery
	   ▪ Objective 6 – Plan for and Coordinate Health Care Evacuation and Relocation
	      ➢ Activity 2 – Develop and Implement Evacuation Transportation Plans
	• Capability 4 – Medical Surge
	   ▪ Objective 1 – Plan for a Medical Surge
	      ➢ Activity 3 – Incorporate Medical Surge into a Health Care Coalition Response Plan

PM Description	Capability

PM21: Time [in minutes] for the HCCs to identify an appropriate mode of transport for the last evacuating patient.	• Capability 2 – Health Care and Medical Response Coordination
	    ▪ Objective 1 – Develop and Coordinate Health Care Organization and Health Care Coalition Response Plans
	        ➢ Activity 2 – Develop a Health Care Coalition Response Plan
	    ▪ Objective 3 – Coordinate Response Strategy, Resources, and Communications
	        ➢ Activity 1 – Identify and Coordinate Resource Needs during an Emergency
	• Capability 3 – Continuity of Health Care Service Delivery
	    ▪ Objective 6 – Plan for and Coordinate Health Care Evacuation and Relocation
	        ➢ Activity 2 – Develop and Implement Evacuation Transportation Plans
	• Capability 4 – Medical Surge
	    ▪ Objective 1 – Plan for a Medical Surge
	        ➢ Activity 3 – Incorporate Medical Surge into a Health Care Coalition Response Plan

PM22: Percent of hospitals with an Emergency Department (ED) recognized through a statewide, territorial, or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies.	• Capability 4 – Medical Surge
	    ▪ Objective 2 – Respond to a Medical Surge
	        ➢ Activity 4 – Provide Pediatric Care during a Medical Surge Response

PM23: Percent of HCC core member organizations participating in the Command Center Table Top and Emergency Department Table Top during the Hospital Surge Test.	• Capability 1 – Foundation for Health Care and Medical Readiness
	    ▪ Objective 1 – Establish and Operationalize a Health Care
	        ➢ Activity 2 – Identify Health Care Coalition Members
	        ➢ Activity 3 – Establish Health Care Coalition Governance
	    ▪ Objective 4 – Train and Prepare the Health Care and Medical Workforce
	        ➢ Activity 3 – Plan and Conduct Coordinated Exercises with Health Care Coalition Members

PM24: Percent of HCC core member organizations' executives participating in the After Action Review of the Hospital Surge Test.	• Capability 1 – Foundation for Health Care and Medical Readiness
	    ▪ Objective 5 – Ensure Preparedness is Sustainable
	        ➢ Activity 2 – Engage Health Care Executives

PM Description	Capability

PM25: Percentage of ICU beds made available during the Hospital Surge Test.	- Capability 4 – Medical Surge
	   ▪ Objective 2 – Respond to a Medical Surge
	      ➢ Activity 1 – Implement Emergency Department and Inpatient Medical Surge Response

PM26: Percentage of non-ICU beds made available during the Hospital Surge Test.	- Capability 4 – Medical Surge
	   ▪ Objective 2 – Respond to a Medical Surge
	      ➢ Activity 1 – Implement Emergency Department and Inpatient Medical Surge Response

PM27: Percentage of emergency department beds made available during the Hospital Surge Test.	- Capability 4 – Medical Surge
	   ▪ Objective 2 – Respond to a Medical Surge
	      ➢ Activity 1 – Implement Emergency Department and Inpatient Medical Surge Response

PM28: Percentage of patients with a bed identified in the emergency department during the Hospital Surge Test.	- Capability 4 – Medical Surge
	   ▪ Objective 2 – Respond to a Medical Surge
	      ➢ Activity 1 – Implement Emergency Department and Inpatient Medical Surge Response

Appendix 5: Required Components of Preparedness and Response Plans

Complete Preparedness and Response Plans have all of the required components identified in the FOA as well as the *2017-2022 Health Care Preparedness and Response Capabilities.* HCCs may elect to address the components associated with the Preparedness and Response Plans in two separate documents or in multiple documents; however, all components must be documented. Required components of each plan as identified in the FOA, include:

Required Components of a Preparedness Plan

Each HCC funded by the awardee **must** develop a preparedness plan and submit the plan to ASPR by the end of Budget Period 1 with the annual progress report (APR). The HCC **must** develop its preparedness plan to include core HCC members and additional HCC members so that, at a minimum, hospitals, EMS, emergency management organizations, and public health agencies are represented. The HCC preparedness plan must emphasize strategies and tactics that promote communications, information sharing, resource coordination, and operational response planning with HCC members and other stakeholders.

HCC members should approve the initial preparedness plan and maintain involvement in no less than annual reviews. The final preparedness plan **must** be approved by all its core member organizations. The review should include identifying gaps in the preparedness plan and working with HCC members to define strategies to address the gaps. Following reviews, the HCC **must** update the plan as necessary after exercises and real incidents. All of the HCC's additional member organizations **must** be given an opportunity to provide input into the preparedness plan, and all member organizations **must** receive a final copy of the plan.

Each preparedness plan can be presented in various formats, including a subset of strategic documents, annexes, or a portion of the HCC's concept of operations (CONOPS) plans; however, at a minimum the HCC preparedness plan **must**:

- Incorporate the HCC's and its associated members' priorities for planning and coordination based on regional needs and gaps. Priorities will depend on multiple factors including perceived risk, emergencies occurring in the region, available funds, applicable laws and regulations, supporting personnel, HCC member facilities and organizations involved, and time constraints
- Leverage HCC members' existing facility preparedness plans as required by the CMS Emergency Preparedness Rule: Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers
- Be developed by HCC leadership with broad input from HCC members and other stakeholders
- Outline strategic and operational objectives for the HCC as a whole and for each HCC member
- Include short-term—within the year—and longer-term—three- to five-year—objectives
- Include a recurring objective to develop and review the HCC response plan, which details the responsibilities and roles of the HCC and its members, including how they share information, coordinate activities and resources during an emergency, and plan for recovery
- Inform training, exercise, and resource and supply management activities during the year.
- Include a checklist of each HCC member's proposed activities, methods for members to report progress to the HCC, and processes to promote accountability and completion.

More information about the HCC Preparedness Plan can be found in Capability 1, Objective 3 of the
2017-2022 Health Care Preparedness and Response Capabilities.

Required Components of a Response Plan

Each HCC funded by the awardee **must** develop a response plan that is informed by its members' individual emergency operations plans and submit the plan to ASPR by the end of Budget Period 2 with annual progress reports. Each HCC's response plan **must** describe the HCC's operations that support strategic planning, information sharing, and resource management. The plan **must** also describe the integration of these functions with the ESF-8 lead agency to ensure information is provided to local officials and to effectively communicate and address resource and other needs requiring ESF-8 assistance. In cases where the HCC serves as the ESF-8 lead agency, the HCC response plan may be the same as the ESF-8 response plan.

The interests of all members and stakeholders should be considered in the response plan; however, each HCC **must** coordinate the development of its response plan by involving core members and other HCC members so that, at a minimum, hospitals, EMS, emergency management organizations, and public health agencies are represented in the plan. Each HCC **must** review and update its response plan regularly, and after exercises and real incidents.

The HCC response plan can be presented in various formats, including the placement of information described below in a supporting annex. Regardless of the format, each HCC's response plan **must** clearly outline:

- Individual HCC member organization and HCC contact information,
- Locations that may be used for multiagency coordination,
- Process for multiagency coordination if location is virtual,
- A brief summary of each individual member's resources and responsibilities,
- Integration with appropriate ESF-8 lead agencies,
- Emergency activation thresholds and processes
- Alert and notification procedures,
- EEIs agreed to be shared, including information format, such as bed reporting, resource requests and allocation, and patient distribution, and tracking procedures,
- Communication and IT platforms and redundancies for information sharing,
- Support and mutual aid agreements,
- Evacuation and relocation processes,
- Additional HCC roles and responsibilities as determined by state or local plans and agreements such as staff sharing, alternate care sites, and shelter support, and
- Activation and notification processes for initiating and implementing medical surge response coordination among HCC members and other topics related to medical surge, including:

  - Strategies to implement if the emergency overwhelms regional capacity or specialty care including trauma, burn, and pediatric capability,
  - Strategies for patient tracking,
  - Strategies for initial patient distribution (or redistribution) across the region, among local hospitals in the event a facility becomes overwhelmed, and
  - Processes for joint decision making and engagement among the HCC, HCC members, state and local public health agencies, and emergency management organizations to avoid crisis conditions based on proactive decisions about resource utilization.

Each HCC should also monitor their members' progress toward closing gaps in their own plans and offer assistance to help close the gaps as appropriate.

More information about the HCC Response Plan can be found in Capability 2, Objective 1, Activity 2 of the *2017-2022 Health Care Preparedness and Response Capabilities*.