2019-2023 Hospital Preparedness Program

Performance Measures Implementation Guidance

Administration for Strategic Preparedness and Response

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ASPR
ADMINISTRATION FOR STRATEGIC PREPAREDNESS AND RESPONSE

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

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Acronyms

AAR/IP	After Action Report and Improvement Plan
ABA	American Burn Association
AS	American Samoa
APR	Annual Progress Report
ARI	At-Risk Individuals Programs
ASPR	Administration for Strategic Preparedness and Response
CAT	Coalition Assessment Tool
CFR	Code of Federal Regulations
CNMI	Commonwealth of the Northern Mariana Islands
CMS	Centers for Medicare & Medicaid Services
CST	Coalition Surge Test
CONOPS	Concept of Operations
CSC	Crisis Standards of Care
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-8	Emergency Support Function-8
FOA	Funding Opportunity Announcement
FPO	Field Project Officer
GIS	Geographic Information System
HAI	Healthcare-Associated Infection
HAZMAT	Hazardous Materials
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
HRSA	Health Resources and Services Administration

HSEEP	Homeland Security Exercise and Evaluation Program
HST	Hospital Surge Test
ICS	Incident Command System
ICU	Intensive Care Unit
IT	Information Technology
JRA	Jurisdictional Risk Assessment
MCM	Medical Countermeasures
MCM ORR	Medical Countermeasures Operational Readiness Review
MRSE	Medical Response and Surge Exercise
MOU	Memorandum of Understanding
NHPP	National Healthcare Preparedness Programs
NICU	Neonatal Intensive Care Unit
NOAA	National Oceanographic and Atmospheric Administration
PHEP	Public Health Emergency Preparedness
PM	Performance Measure
POD	Point of Dispensing
PPE	Personal Protective Equipment
RITN	Radiation Injury Treatment Network
RCD	Redundant Communications Drill
SPPR	Office of Strategy, Policy, Planning, and Requirements
TRACIE	Technical Resources, Assistance Center, and Information Exchange
TTX	Table-Top Exercise
UASI	Urban Area Security Initiative
USVI	U.S. Virgin Islands
USDA	United States Department of Agriculture
VOIP	Voice-Over Internet Protocol

Background

The U.S. Department of Health and Human Services (HHS) Administration for Strategic 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) Cooperative Agreement 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 primary source of federal funding for health care delivery system readiness and response- 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), which have differing priorities and objectives, to work together.

2017-2022 Health Care Preparedness and Response Capabilities

ASPR developed the original *2017-2022 Health Care Preparedness and Response Capabilities* (which remain the same for the FY 2019-2023 cooperative agreement) to describe the high-level objectives that the health care delivery system and HCCs, including acute care hospitals, and emergency medical services (EMS), emergency management agencies, and public health agencies, 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

The community's health care organizations and other stakeholders—coordinated through a sustainable HCC—have strong relationships, identify hazards and risks, and prioritize and address gaps through planning, training, exercising, and managing resources.

Capability 2: Health Care and Medical Response Coordination

Health care organizations, the HCC, their jurisdiction(s), and the state's/jurisdiction's Emergency Support Function-8 (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

Health care organizations, with support from the HCC and the state's/jurisdiction's 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, well-educated, and well-equipped to care for patients during emergencies. Simultaneous response and recovery operations result in a return to normal or, ideally, improved operations.

Capability 4: Medical Surge

Health care organizations—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 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 public health and medical services lead agencies. Given the many public and private entities that 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.

2019 Hospital Preparedness Program (HPP) Funding Opportunity Announcement (FOA)

In 2019, ASPR released the Hospital Preparedness Program Cooperative Agreement CFDA #93.889. This FOA provides updates to the program but maintains performance measures and standards for measurement of recipient and HCC compliance and the health care preparedness and response capabilities.

Significant Updates for FY 2019-2023

In FY 2019, the program added specialty surge annex requirements to response plans. In light of the COVID-19 response, the pediatric annex table-top exercise (TTX) and associated data sheet were waived for FY 2019. However, pediatric surge is very important; the pediatric annex TTX and associated data sheet will still need to be conducted before the end of the five-year project period.

Also due to the COVID-19 response, the response plan specialty annex due in FY 2020 may be either the burn specialty annex, as planned, or the infectious disease specialty annex. The other annex not completed in FY 2020 should be completed in FY 2021.

The preparedness plan measure has been retired (as HCCs were overwhelmingly meeting this measure), and refinements in language have been made to clarify some performance measures. In addition, for Performance Measure 4, the number of core and additional organizations (both member organizations and non-member organizations) within recipient boundaries, disaggregated by type, will now be reported by recipients rather than through HCCs.

In FY 2021, ASPR created the Medical Response and Surge Exercise (MRSE) which officially replaces both the Coalition Surge Test (CST) and the Hospital Surge Test (HST). The MRSE is an annual Hospital Preparedness Program (HPP) Cooperative Agreement requirement and as of HPP Budget Period 3 (starting on July 1, 2021 and ending June 30, 2022), HCCs must complete the MRSE annually. In FY 2021, in recognition of the ongoing challenges presented to the health care system by the COVID-19 pandemic, ASPR allowed HCCs to conduct the MRSE in either FY 2021 or in FY 2022. The MRSE must be conducted at least once by each HCC by the end of FY 2022. Previously, the HST was used for hospitals located in approved jurisdictions or officially classified as an isolated frontier hospital. Now hospitals located in approved jurisdictions (American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Republic of Palau, Republic of the Marshall Islands, Guam, and the

United States Virgin Islands) or officially classified as an isolated frontier hospital must also complete the MRSE.

Introduction to the 2019-2023 HPP Performance Measures Implementation Guidance

The PMs were developed to align to the core concepts of the capabilities and the funding opportunity announcement (FOA), to evaluate program performance, and to 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, these PMs 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, recipients, 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 most recent FOA, released in March 2019. For more information on stakeholder engagement, see Appendix 1: The 2017-2022 HPP Performance Measures Development Process for more details.

Using this Document

The *2019-2023 Hospital Preparedness Program Performance Measures Implementation Guidance* document is framed for the primary users—recipients 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 recipient and HCC progress toward meeting the goals of the four capabilities detailed in the *2017-2022 Health Care Preparedness and Response Capabilities*. Performance measures are organized into five sections:

Section 1: Input, Activity, and Output Performance Measures

This section includes PMs 1 to 11 that gauge progress at both the recipient 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: Medical Response and Surge Exercise Performance Measures

This section contains PMs 14 to 21 that use data produced while conducting the Medical Response and Surge Exercise (MRSE). To gauge the full extent of HCC performance, ASPR selected eight PMs in this section to assess the extent to which HCCs can coordinate to meet their needs during a medical surge incident. The eight PMs assess participation in the MRSE and percent-based outcomes regarding the ability of HCCs to coordinate patient load sharing and resource-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. Recipients 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 will share the data with ASPR.

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 EMSC and PHEP joint measures (22, 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 ASPR at a later date after data from the initial fiscal years have 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 are 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—recipient, HCC, or hospital.
    - **Data Source:** The data source includes examples of documentation or systems where PM data are 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

ASPR uses the data reported from three fiscal years to establish a baseline for recipients and HCCs, unless otherwise noted in the Goal or Target section of the PM. Additional targets and goals will be set by ASPR based on baseline data, benchmarks, and/or program requirements. Achievement in future budget years will be determined by comparing recipients and HCCs against previously reported data and their peers or a subset of their peers, such as those sharing similar demographics, resources, and risk profiles, among other characteristics.

HPP Performance Measure Requirements

The following HPP PM requirements apply to all recipients, HCCs, 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, Guam, and Republic of the Marshall Islands) and those designated as Remote and Isolated Frontier Hospitals.

Annual Requirement to Exercise the MRSE

All HCCs, U.S. Territories, Freely Associated States, and those designated as Remote and Isolated Frontier Hospitals that receive HPP funding are required to conduct the MRSE annually. Data from the MRSE are used to respond to PMs 14 to 21, collected using the associated evaluation tools as identified in this performance measures implementation guidance. The detailed MRSE Situation Manual and Evaluation Plan can be viewed online. Please note that the MRSE Exercise Planning and Evaluation Tool is available on the Coalition Assessment Tool (CAT).

If an HCC has a real-world incident with a medical surge component that is equal to or greater than 20% of the required bed types and other scenario-specific bed types used in the MRSE during the performance year, the HCC can use the data from the real-world incident to fully complete the MRSE Real-World Incident Reporting and Evaluation Tool or the MRSE Exercise Planning and Evaluation Tool and report upon each PM. The HCC must still submit an After-Action Report and Improvement Plan (AAR/IP) if a real-world incident is used in lieu of the MRSE during the reporting year.

Optimized HCCs with Response Capabilities

HCCs 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—acute care hospitals, EMS, emergency management agencies, 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 2: List of Core and Additional HCC Member Types.

Overview of Performance Measures for Select U.S. Territories, Freely Associated States, and Remote and Isolated Frontier Communities

These measures only apply to the U.S. Territories of American Samoa, Commonwealth of Northern Marianas, and U.S. Virgin Islands; the Freely Associated States of Federated States of Micronesia, Republic of Palau, and Republic of the Marshall Islands; and to Remote and Isolated Frontier Communities. The U.S. Territories of Guam and Puerto Rico are not included in this category. The select U.S. Territories, Freely Associated States, and Remote and Isolated Frontier Communities have unique risk profiles, resource constraints, supply chains, and regulatory requirements compared to the rest of the recipients and HCCs receiving HPP funding.

In the following table, the reporting requirements are cross walked to each PM: a ‘Yes’ indicates the PM shall be reported, and 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)**	**Remote and Isolated Frontier Communities**
1	1	Yes	Yes	Yes
1	2	Yes	Yes	Yes
1	3	Yes	Yes	Yes
1	4	Yes	Yes	Yes
1	5	Yes	Yes	Yes
1	6	Yes	Yes	Yes
1	7	Yes	No	No
1	8	Yes	Yes	Yes
1	9	Yes	Yes	Yes
1	10	Yes	Yes	Yes
1	11	Yes	Yes	Yes
2	12-13	Yes	Yes	Yes
3	14-21	Yes	Yes	Yes

Section 1: Input, Activity, and Output Performance Measures

This section contains input, activity, and output PMs aligned to the requirements of the 2019 FOA and the preparedness and response capabilities. For a crosswalk of PMs to the *2017-2022 Health Care Preparedness and Response Capabilities*, see Appendix 3: 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 (recipient or HCC)—and PM type for each PM:

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

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 recipient, other federal sources, and non-federal sources

Goal or Target

Within 30 days following receipt of the subaward, all funded HCCs must submit their final budgets to their recipient. Recipients should report this information in PERFORMS. The budget should identify the percent of funding received from the recipient, other federal sources, and non-federal sources. ASPR will use this measure as a benchmark to assess achievement of preparedness goals for the health care system. Pursuant to Section 319C-1(g)(5) of the Public Health Service Act, failure to achieve this benchmark for one of two consecutive years may result in withholding of 10 percent of funding amounts and increased withholding amounts in subsequent years in which this benchmark is not met.

Operational Intent

This PM 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 recipient to help assess diversity of support.

Data Reporting

Each HCC should report the following data in the Coalition Assessment Tool (CAT). Recipients should enter this information into the end-of-year performance measure module in PERFORMS during the specified time period for end-of-year reporting. ASPR will calculate percentages.

Data Point	Data Entity	Data Source	Response
PM1.1 Total HPP funding amount each HCC received from the recipient	HCC	HCC Operating Budget	HCC Name:_____ $_____
PM1.2 Total funding each HCC received from other federal sources	HCC	HCC Operating Budget	HCC Name:_____ $_____
PM1.3 Total funding each HCC received from non-federal sources	HCC	HCC Operating Budget	HCC Name:_____ $_____
PM1.4 Total funding each HCC received from all sources	HCC	HCC Operating Budget	HCC Name:_____ $_____
PM1.5 The HCC receives in-kind support from sources other than the recipient in the form of (check all that apply)	HCC	HCC Operations Documents	HCC Name:_____ ☐ Physical Space ☐ Equipment/Supplies ☐ Services ☐ Labor Hours

Data Point	Data Entity	Data Source	Response
			☐ Other ☐ None received

Definitions and Interpretation

- **Funding:** In this case, funding means the program funds distributed by HPP. Funding includes all allocations to the HCC during the fiscal year from July 1 to June 30. The percent is calculated by ASPR from the data points collected from the recipient on behalf of the HCC. Carryover funding is not reported under allocations.
- **From the recipient:** The total amount of funding made directly available to the HCC from the recipient or its agent (e.g., if the recipient distributes funding to a state hospital association that then funds the HCC, the HCC reports the amount of funding made available from the state hospital association).
- **Other federal sources:** The total amount of funding made directly 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 recipient:** Any non-monetary support for HCC activities received from sources other than the recipient. For further definitions of in-kind support, see 45 Code of Federal Regulation (CFR), Part 75 at https://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75.
- **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 the start of the fiscal year (July 1) for recipients to execute subawards with each HCC

Goal or Target

Recipients must execute subawards with each HCC within 90 calendar days from the start of each fiscal year (July 1). **ASPR will use this measure as a benchmark to assess achievement of preparedness goals for the health care system. Pursuant to Section 319C-1(g)(5) of the Public Health Service Act, failure to achieve this benchmark for one of two consecutive years may result in withholding of 10 percent of funding amounts and increased withholding amounts in subsequent years in this benchmark is not met.**

Operational Intent

This PM provides insight into fiscal preparedness and the ability of recipients 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 can begin work and access HPP funding, and the greater their likelihood is of having sufficient time to complete subaward activities.

Data Reporting

Recipients should report the date each subaward was executed with each HCC into the end-of-year performance measure module in PERFORMS (during the specified time period for end-of-year reporting). ASPR will calculate duration from start of the fiscal year (July 1).

Data Point	Data Entity	Data Source	Response
PM2.1 Date(s) subaward(s) are executed	Recipient	Executed subaward agreements	HCC Name:_____ Date Executed:_____

Definitions and Interpretation

- **Number of calendar days:** Calendar days, inclusive of weekends, holidays, and leap day (if applicable).
- **Start of fiscal year:** July 1 is the start date of each fiscal year. If extenuating circumstances prevent the timely award of HPP awards to recipients before or on this date, this start date will be adjusted to reflect the federal government's delay in awarding funds to the recipients.
- **Recipients to execute subawards:** The regular process by which recipients 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 is generally not allowed.
- **With each HCC:** While the recipient is responsible for reporting this measure, the date of subaward execution should only be calculated from when the HCC and only the HCC receives an executed subaward from the recipient. If a recipient 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

Number of calendar days from start of the fiscal year (July 1) for recipients to provide a detailed spend plan, including all budget line items, to all HCCs within their jurisdiction and any interested health care entity

Goal or Target

Within the first 60 days of the start of each fiscal year (July 1), all recipients must provide a detailed spend plan, including all budget line items, to all HCCs within their jurisdiction and any interested health care entity.

ASPR will use this measure as a benchmark to assess achievement of preparedness goals for the health care system. Pursuant to Section 319C-1(g)(5) of the Public Health Service Act, failure to achieve this benchmark for one of two consecutive years may result in withholding of 10 percent of funding amounts and increased withholding amounts in subsequent years in which this benchmark is not met.

Operational Intent

This PM provides insight into fiscal preparedness and the ability of recipients to provide clear and transparent financial information to HCCs in a timely manner.

Data Reporting

Recipients should enter this information into the end-of-year performance measure module in PERFORMS during the specified time period for end-of-year reporting. ASPR will calculate duration from start of the fiscal year (July 1).

Data Point	Data Entity	Data Source	Response
PM3.1 Date(s) detailed spend plan and budget provided to all HCCs in the jurisdiction.	Recipient	Notice of Grant Award and HCC Correspondence	HCC Name:_____ Date Executed:_____

Definitions and Interpretation

- **Number of calendar days:** Calendar days, inclusive of weekends, holidays, and leap day (if applicable).
- **Start of fiscal year:** July 1 is the start date of each fiscal year. If extenuating circumstances prevent the timely award of HPP awards to recipients before or on this date, this start date will be adjusted to reflect the federal government's delay in awarding funds to the recipients.
- **Recipients to provide a detailed spend plan:** The regular process by which recipients award 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 is generally not allowed.

Performance Measure 4

Membership representation rate of HCC core (acute care hospitals, EMS, emergency management agencies, and public health agencies) and additional member organizations by member type

Goal or Target

Per the FOA, recipients are not permitted to use HPP funds to make subawards to any HCC that does not have core member representation. Core member organizations include, at least, the following:

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

ASPR has set a target for the membership representation rate of each core member, as described below. At the national level, ASPR seeks to have the following member representation for each core member type within an HCC:

- 96 percent of acute care hospitals
- 60 percent of EMS organizations
- 86 percent of emergency management agencies
- 98 percent of public health agencies

Operational Intent

The intent of this PM is to 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 simply having more members does not necessarily mean greater capacity to prepare and respond to hazards. Therefore, the intent of this measure is to assess appropriate HCC membership representation, including mix of member organizations and types, based on the unique preparedness and responses needs of the HCC's communities.

Data Reporting

Recipients should enter this information for each HCC into the end-of-year performance measure module in PERFORMS during the specified time period for end-of-year reporting. ASPR will calculate percentages. See Appendix 2: 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	Member type, legal name (no abbreviations), and address for each HCC core member organization
Total number of core member organizations within recipient boundaries, disaggregated by member type	Recipient	Recipient Documentation	Enumerate how many total of the core member organization type are within jurisdiction
Additional member organizations represented in the HCC, disaggregated by member type	HCC	HCC Governance Documents	Member type, legal name (no abbreviations), and address for each HCC additional member organization
Total number of additional member organizations within recipient boundaries, disaggregated by member type	Recipient	Recipient Documentation	Enumerate how many total of the core member organization type are within jurisdiction

Definitions and Interpretation

- **Membership representation:** Membership is evidenced by memoranda of understanding (MOU), letters of agreement, and/or attendance at an HCC meeting in the past fiscal year. 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). For example, if a subcommittee lead participates in an HCC meeting, 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 agencies, and public health agencies. See Appendix 2: 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 2: 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

ASPR has set a target of 100 percent of HCCs completing a response plan with 100 percent approval by the core member organizations of each HCC for every fiscal year.

ASPR has set a target of 100 percent of additional member organizations providing an opportunity to provide input into the response plan, and 100 percent of core and additional member organizations receiving a final copy of the response plan.

Operational Intent

This PM determines the percent of HCCs that 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 4: Required Components of a Response Plan for more information) and may be updated in future budget years' continuation guidance.

Data Reporting

Recipients should enter this information into the end-of-year performance measure module in PERFORMS during the specified time period for end-of-year reporting. ASPR will calculate percentages.

Data Point	Data Entity	Data Source	Response
PM5.1 The HCC has a complete response plan with the required components	HCC	Response Plan	Yes/No/In Progress
PM5.2 The HCC has a response plan that has been approved by all of its core member organizations	HCC	Response Plan	Yes/No/In Progress
PM5.3 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	Yes/No/In Progress

Data Point	Data Entity	Data Source	Response
(must meet both portions of measure to respond "Yes")			

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 response plans have all of the required components identified in the 2019 FOA as well as the *2017-2022 Health Care Preparedness and Response Capabilities*. See Appendix 4: Required Components of a Response Plan for more information. Additional guidance on the components of the response plan 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 agencies, and public health agencies. See Appendix 2: List of Core and Additional HCC Member Types for a full list.
- **HCC additional member organizations:** See Appendix 2: List of Core and Additional HCC Member Types for a full list.

Performance Measure 6

Percent of HCCs that have a complete and approved response plan annex addressing the required annual specialty surge requirement

Goal or Target

ASPR has set a target of 100 percent of HCCs submitting a draft and final response plan specialty surge annex each fiscal year. Final plans must be submitted with the Annual Progress Report (APR).

ASPR has set a target of each HCC's specialty surge annex having 100 percent approval by the core member organizations of each HCC for every fiscal year.

ASPR has set a target of 100 percent of additional member organizations providing an opportunity to provide input into the specialty surge annex, and 100 percent of core and additional member organizations have received a final copy of the response plan annex.

HCCs must have a draft response plan annex addressing burn care surge or infectious disease preparedness and surge completed and uploaded in the CAT by April 1, 2022. Final plans must be submitted with the FY 2021 APR. ASPR will use this measure as a benchmark to assess achievement of preparedness goals for the health care system. Pursuant to Section 319C-1(g)(5) of the Public Health Service Act, failure to achieve this benchmark for one of two consecutive years may result in withholding of 10 percent of funding amounts and increased withholding amounts in subsequent years that this benchmark is not met.

Operational Intent

Integration of complementary coalition-level specialty surge annexes will support HCC management of large numbers of casualties with specific needs. Recipients should incorporate the HCC annexes into their jurisdiction's plan for awareness and support coordination of state resources. Each specialty surge annex framework should be similarly formatted and emphasize the following core elements:

- Indicators/triggers and alerting/notifications of a specialty event
- Initial coordination mechanism and information gathering to determine impact and specialty needs
- Documentation of available local, state, and interstate resources that can support the specialty response and key resource gaps that may require external support (including inpatient and outpatient resources)
- Access to subject matter experts– local, regional, and national
- Prioritization method for specialty patient transfers (e.g., which patients are most suited for transfer to a specialty facility)
- Relevant baseline or just-in-time training to support specialty care

In addition to the general requirements above, the specialty surge annex must address additional factors per each of the specialties listed below (depending upon which is exercised which year):

- Pediatric (FY 2019)
    - Local risks for pediatric-specific mass casualty events (e.g., schools, transportation accidents)
    - Age-appropriate medical supplies
    - Mental health and age-appropriate support resources
    - Pediatric/Neonatal Intensive Care Unit (NICU) evacuation resources and coalition plan
    - Coordination mechanisms with dedicated children's hospital(s)
- Burn (FY 2020 or FY 2021)[1]
    - Local risks for mass burn events (e.g., pipelines, industrial, terrorist, transportation accidents)
    - Burn-specific medical supplies
    - Coordination mechanisms with American Burn Association (ABA) centers/region
    - Incorporation of critical care air/ground assets suitable for burn patient transfer
- Infectious Disease (FY 2020 or FY 2021)[2]
    - Expanding existing Ebola concept of operations (CONOPS) plans to enhance preparedness and response for all novel/high consequence infectious diseases
    - Developing coalition-level anthrax response plans
    - Developing coalition-level pandemic response plans
    - Including healthcare-associated infection (HAI) professionals at the health care facility and jurisdictional levels in planning, training, and exercises/drills
    - Developing a continuous screening process for acute care patients and integrating information with electronic health records (EHRs) where possible in HCC member facilities and organizations

[1] Due to the Coronavirus Disease 2019 (COVID-19), HCCs must develop either the Burn Care Surge Annex or the Infectious Disease Preparedness and Surge Annex in FY 2020 and must develop the other in FY 2021.
[2] Due to the Coronavirus Disease 2019 (COVID-19), HCCs must develop either the Burn Care Surge Annex or the Infectious Disease Preparedness and Surge Annex in FY 2020 and must develop the other in FY 2021.

    - Coordinating visitor policies for infectious disease emergencies at member facilities to ensure uniformity
    - Coordinating medical countermeasures (MCM) distribution and use by health care facilities for prophylaxis and acute patient treatment
    - Developing and exercising plans to coordinate patient distribution for highly pathogenic respiratory viruses and other highly transmissible infections, including complicated and critically ill infectious disease patients, when tertiary care facilities or designated facilities are not available
- Radiation (FY 2022)
    - Local risks for radiation mass casualty events (e.g., power plant, industrial/research, radiological dispersal device, nuclear detonation)
    - Detection and dosimetry equipment for EMS/hospitals
    - Decontamination protocols
    - On-scene triage/screening, assembly center, and community reception center activities
    - Treatment protocols/information
    - Coordination mechanisms with hematology/oncology centers and Radiation Injury Treatment Network (RITN)
- Chemical (FY 2023)
    - Determine risks for community chemical events (e.g., industrial, terrorist, transportation-related)
    - Decontamination assets and throughput (pre-hospital and hospital), including capacity for dry decontamination
    - Determine EMS and hospital personal protective equipment (PPE) for HAZMAT events
    - Review and update CHEMPACK (and/or other chemical countermeasure) mobilization and distribution plan
    - Coordinate training for HCC members on the provision of wet and dry decontamination and screening to differentiate exposed from unexposed patients
    - Ensure involvement and coordination with regional HAZMAT resources (where available) including EMS, fire service, health care organizations, and public health agencies (for public messaging)
    - Develop plans for a community reception center with public health partners

ASPR has clarified the special surge annex tabletop/discussion exercise format and data sheet requirement for each required specialty surge annex, i.e., FY 2019 Pediatric Care Surge Annex, FY 2020 Burn Care Surge Annex or Infectious Disease Preparedness and Surge Annex, FY 2021 Burn Care Surge Annex or Infectious Disease Preparedness and Surge Annex, FY 2022 Radiation Emergency Surge Annex, and FY 2023 Chemical Emergency Surge Annex). Recipients and HCCs **must** validate their specialty surge annexes via a standardized tabletop/discussion exercise format that meets Homeland Security Exercise and Evaluation Program (HSEEP) principles for exercises and planning. The data sheet is a web-based form, being developed as a module in the CAT where the data can be input directly. Detailed instructions will be provided regarding the specific information that should be entered into the CAT.

ASPR has clarified the requirement for incorporating transfer agreements into corresponding specialty surge annexes. Transfer agreements with pediatric, trauma, and burn centers should be referenced in the corresponding HCC specialty surge annexes. HCCs are not required to obtain a copy of all transfer agreements, nor do they need to be included in the annex; however, HCCs should be capable of demonstrating their knowledge of existing transfer agreements that support each specialty surge annex. HPP FPOs will verify the availability of transfer agreements during recipient site visits. ASPR understands that some specialty centers do not use written transfer agreements but will always accept referrals

subject to resources available. If this the case, a statement by the specialty center to this effect will suffice.

Data Reporting

During the specified time period for end-of-year reporting, recipients should enter this information on behalf of each HCC into the end-of-year performance measure module in PERFORMS. ASPR will calculate percentages.

Data Point	Data Entity	Data Source	Response
PM6.1 The HCC has a complete Specialty Surge Annex with the required components	HCC	Specialty Surge Annex	Yes/No/In Progress
PM6.2 The HCC has a Specialty Surge Annex that has been approved by all of its core member organizations	HCC	Specialty Surge Annex	Yes/No/In Progress
PM6.3 All of the HCC's additional member organizations have been given an opportunity to provide input into the Specialty Surge Annex, and all member organizations have received a final copy of the plan (must meet both portions of measure to respond 'Yes')	HCC	Specialty Surge Annex	Yes/No/In Progress

Performance Measure 7

Part A: Percent of recipients that access the de-identified emPOWER data map at least once every six months to identify the number of individuals with electricity-dependent medical and assistive equipment for planning purposes

Part B: Percent of HCCs that access the de-identified emPOWER data map at least once every six months to identify the number of individuals with electricity-dependent medical and assistive equipment for planning purposes

Goal or Target

ASPR has set a target of 100 percent of recipients and HCCs accessing the de-identified emPOWER data map at least once every six months.

Please note, recipients and HCCs from American Samoa (AS), Commonwealth of the Northern Mariana Islands (CNMI), and the U.S. Virgin Islands (USVI) territories are also required to report. No other territories are required to report performance for this measure.

Operational Intent

This PM helps ASPR determine if recipients and HCCs have up-to-date data on populations with electricity-dependent medical and assistive equipment in their jurisdictions for planning purposes. Recipients and HCCs should be planning how to address the needs of these populations during an

emergency. The number of individuals with electricity-dependent medical and assistive equipment from emPOWER represents a minimum of potential population needs in an emergency. Recipients and HCCs should at least plan for population needs based on emPOWER data, although actual needs of the population are certainly greater, as emPOWER data do not capture populations with electricity-dependent medical and assistive equipment who are covered by Medicaid, including children. Recipients 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 through the CAT. During the specified time period for end-of-year reporting, recipients should enter this information on behalf of themselves and HCCs into the end-of-year performance measure module in PERFORMS. ASPR will calculate percentages.

Data Point	Data Entity	Data Source	Response
PM7.1 The recipient accesses the de-identified data map from emPOWER at least once every six months to identify numbers of individuals with electricity-dependent medical and assistive equipment for planning purposes	Recipient*	Meeting notes, agendas, or other operational documents	Recipient Name: _____ ☐ Yes ☐ No
PM7.2 The HCC accesses the de-identified data map 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

*American Samoa (AS), Commonwealth of the Northern Mariana Islands (CNMI), and the U.S. Virgin Islands (USVI) territories are also required to report. No other territories are required to report.

Definitions and Interpretation

- **Access the de-identified data map from emPOWER:** the emPOWER data map can be accessed at http://empowermap.hhs.gov/. De-identified data are Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant.
- **emPOWER:** emPOWER, developed by HHS ASPR and the Centers for Medicare & Medicaid (CMS), 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 who use 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 fiscal year is 12 months. A recipient and HCC should access emPOWER data map at least once every six months.

Identify the number of individuals with electricity-dependent medical and assistive equipment: The HHS emPOWER Map displays the total number of Medicare beneficiaries who live independently and rely on electricity-dependent durable medical and assistive equipment and devices at the state, territory, county, and ZIP Code levels. Note that if the number of individuals in a geographic area is between 1-10, it will be displayed as 11 to minimize the risk of individual re-identification.

Performance Measure 8

Percent of recipients that have provided an opportunity for each HCC to review and provide input to the recipient's ESF-8 response plan

Goal or Target

ASPR has set a target of 100 percent of recipients providing an opportunity for each HCC to review and provide input to their recipient's ESF-8 response plan.

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 in the recipient-level ESF-8 response plans.

Data Reporting

During the specified time period for end-of-year reporting, recipients should enter this information into the end-of-year performance measure module in PERFORMS. ASPR will calculate percentages.

Data Point	Data Entity	Data Source	Response
PM8.1 The recipient has provided an opportunity for each HCC to review and provide input to the recipient's ESF-8 response plan	Recipient	Meeting notes or agenda, website posting, or other documents	Name of HCC:_____ ☐ Yes ☐ No

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 recipient (or the recipient's designated representative) on the plan.
- **ESF-8:** ESF-8 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

[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).* http://nacchopreparedness.org/the-hhs-empower-initiative-emergency-preparedness-tools-addressing-the-needs-of-energy-dependent-at-risk-populations-2/. Accessed on 6 Aug. 2020.

  - 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[4]
- **ESF-8 response plan:** The response plan that the recipient maintains, which describes its intended response to any emergency situation. The response plan, aligned with ESF-8, provides action guidance for management and emergency response personnel during the response phase.

Performance Measure 9

Percent of HCCs engaged in their recipient's jurisdictional risk assessment

Goal or Target

ASPR has set a target of 100 percent of HCCs responding 'yes' at least one time between the start of FY 2019 and the end of FY 2023.

Operational Intent

ASPR requires all HPP recipients to participate in or complete a jurisdictional 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 through the CAT. During the specified time period for end-of-year reporting, recipients should enter this information on behalf of each HCC into the end-of-year performance measure module in PERFORMS. ASPR will calculate percentages.

Data Point	Data Entity	Data Source	Response
PM9.1 The HCC has provided input into its recipient's jurisdictional risk assessment	HCC	Written communications, meeting notes, or other operational documents	HCC Name:_____ ☐ Yes ☐ No

Definitions and Interpretation

- **Engaged:** Provided meaningful opportunity to review and provide input to the recipient during the development or update of the jurisdictional risk assessment.
- **Jurisdictional risk assessment (JRA):** Recipients 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 to the functional needs of at-risk individuals.

[4] "Emergency Support Functions." *Public Health Emergency.* http://www.phe.gov/Preparedness/support/esf8/Pages/default.aspx#8. Accessed 6 Aug. 2020.

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' response plans have been revised to reflect improvements

Goal or Target

ASPR has set a target of 100 percent of HCCs providing an opportunity for member organizations to share lessons learned from their facilities' drills and exercises to inform coalition planning with 100 percent of HCCs identifying areas for improvement from exercises or real-world events.

Of the HCCs identifying areas for improvement, ASPR has set a target of 95 percent of HCCs revising response plans over the year to reflect those improvements.

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 recipients 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 through the CAT. During the specified time period for end-of-year reporting, recipients should enter this information on behalf of each HCC into the end-of-year performance measure module in PERFORMS. ASPR will calculate percentages.

Data Point	Data Entity	Data Source	Response
PM10.1 The HCC provides an opportunity for member organizations to share lessons learned from their facilities' drills and exercises to inform coalition planning	HCC	Meeting notes, exercise or drill debrief documents, or AAR/IPs	HCC Name:_____ ☐ Yes ☐ No
PM10.2 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
PM10.3 If yes (to PM10.2), the HCC has revised its response plans in the past year to reflect improvements	HCC	Response plans	HCC Name:_____ ☐ Yes ☐ No

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/IP:** An 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 HSEEP principles, and HPP will provide an optional template for future use.[5]
- **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.

Performance Measure 11

Percent of recipients with a complete, jurisdiction-wide CONOPS that delineates: a) the roles and responsibilities of state agencies during a crisis care situation, b) potential indicators and triggers for state actions, c) actions the state will take to support prolonged crisis care conditions that cannot be rapidly addressed through standard mutual aid or other mechanisms, d) operational framework for state-level information management and policy development, and e) legal and regulatory state actions that may be taken

Goal or Target

ASPR has set a target of 100 percent of recipients completing a Crisis Standards of Care (CSC) concept of operations (CONOPS) by the end of FY 2021. By the end of FY 2021, recipients **must** submit a new or updated CSC CONOPS. By the end of FY 2023, the recipient's CSC CONOPS **must** be incorporated and validated in an HCC-level exercise.

Operational Intent

This PM assesses how many recipients have a complete (either new or updated) CONOPS.

Data Reporting

During the specified time period for end-of-year reporting, recipients should enter this information into the end-of-year performance measure module in PERFORMS. Each recipient is required to also upload a copy of the new or updated CSC CONOPS by June 30, 2021. ASPR will calculate percentages.

[5] "Phase 4: After Action Report and Improvement Planning." *City and County of San Francisco Department of Emergency Management*. http://sfdem.org/phase-4-after-action-report-and-improvement-planning-0. Accessed 6 Aug. 2020.

Data Point	Data Entity	Data Source	Response
PM11.1 The recipient has a complete, jurisdiction-wide CONOPS that delineates: a) the roles and responsibilities of state agencies during a crisis care situation, b) potential indicators and triggers for state actions, c) actions the state will take to support prolonged crisis care conditions that cannot be rapidly addressed through standard mutual aid or other mechanisms, d) operational framework for state-level information management and policy development, and e) legal and regulatory state actions that may be taken	Recipient	CSC CONOPS	☐ Complete ☐ In Progress ☐ No Progress

Definitions and Interpretation

- **Complete, jurisdiction-wide CSC CONOPS:** By the end of FY 2021, recipients must submit a new or updated CSC CONOPS. CONOPS should integrate the following elements, as applicable:
    - Roles and responsibilities of state agencies during a crisis care situation
    - Potential indicators and triggers for state actions
    - Actions the state will take to support prolonged crisis care conditions that cannot be rapidly addressed through standard mutual aid or other mechanisms
    - Operational framework for state-level information management and policy development, including real-time engagement of subject matter experts for technical support, as well as coordination and decision processes for the allocation of scarce resources (e.g., pharmaceuticals or personal protective equipment [PPE]) to the health and medical sector that are subject to state influence or control
    - Legal and regulatory state actions that may be taken to support health care strategies during crisis care conditions, including, as applicable:
        - State declarations and their powers
        - Credentialing and licensure support for intrastate and interstate assistance
        - Provider protection from liability during disasters
        - Support for alternate systems of care in both in health care facilities and alternate environments (such as alternate care sites)
        - Relief from specific regulations that may impede appropriate billing and collection for services rendered under crisis conditions
        - State agency support for crisis care (e.g., EMS regulatory agency relief, hospital licensure requirements, state fire marshal)
    - Actions state will take to comply with federal nondiscrimination laws
    - Actions state will take to engage the community and clinicians for crisis care planning and decision making should be included
    - The recipient should provide an update on other CSC activities in the jurisdictions that are not required above but that are critical to the success of an overarching CSC planning effort, such as exercises, description of the ethical basis for CSC, clinical

decision tools, provider education on CSC concepts, or hospital and EMS system guidance for CSC application.

Section 2: Redundant Communications Drill Performance Measures

This section contains PMs that use data produced by a Redundant Communications Drill (RCD) that is a requirement of the 2019 FOA. For a crosswalk of PMs to the *2017-2022 Health Care Preparedness and Response Capabilities*, see Appendix 3: 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 HCCs cannot depend on just one, or even two, means of communication.

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

PM	Data Entity	PM Type
12	HCC	Activity
13	HCC	Outcome

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 primary communications plan and system/platform and one redundant communications system/platform (not connected to the commercial power grid) at least once every six months

Goal or Target

ASPR has set a target of 95 percent of HCCs responding 'Yes' to both the first and second redundant communication drills at least once every six months (the HCC has drilled their primary communications plan and system/platform and at least one redundant communications system and platform) during each fiscal year.

Operational Intent

Redundant communications 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 communications 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 communications system during each drill as detailed in the FOA drill guidance.

Data Reporting

Each HCC should report these data in the CAT. During the specified time period for end-of-year reporting, recipients should enter this information on behalf of each HCC into the end-of-year performance measure module in PERFORMS. ASPR will calculate percentages.

Data Point	Data Entity	Data Source	Response
PM12.1 Date of First Redundant Communications Drill	HCC	Exercise notes or other operational documents	MM/DD/YYYY
PM12.2 Date of Second Redundant Communications Drill	HCC	Exercise notes or other operational documents	MM/DD/YYYY

Definitions and Interpretation

- **Drilled:** Testing at least one primary and one backup communications system as detailed in the FOA drill guidance.
- **Redundant communications plans and systems/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 (EEI). These plans may include: incident management software; bed and patient tracking systems; EMS information systems; municipal, hospital, and amateur radio systems; satellite telephones; and others. They 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 fiscal year is 12 months long and begins July 1. Each year, the HCC should plan to conduct at least one RCD before December 30 and another RCD between December 30 and June 30.

Performance Measure 13

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

Goal or Target

HCCs should use at least two different systems and platforms in every redundant communications drill. ASPR has set a target of 60 percent of core member organizations responding to the first and second redundant communications drills.

Operational Intent

Having redundant communications systems improves the likelihood that HCCs are able to coordinate response activities during an emergency. HCCs should test their redundant communications 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 communications 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 PM12). RCDs test the true communications capability and limitations of HCCs before real events. For example, if the internet is down, all forms of communication tied to it are down, so HCCs will need a tested and operational back up communications system or platform.

Data Reporting

During the specified time period for end-of-year reporting, recipients should enter this information on behalf of each HCC into the end-of-year performance measure module in PERFORMS. Data will be collected for a maximum of one drill each six months. If no drill is conducted, a checkbox will be provided to indicate this in PERFORMS. In this case, all performance measure reporting for the redundant communications drill will be omitted, as it will not be applicable. ASPR will calculate percentages.

Data Point	Data Entity	Data Source	Response
PM13.1 Primary communication system used by the HCC during the first redundant communications drill	HCC	Drill notes or other operational documents	HCC Name:_____ (Select primary system) ☐ Telephone (landline, fax, Government Emergency Telecommunications Service) ☐ Internet (email, cable, fiber-optic, Voice-Over Internet Protocol [VOIP]) ☐ Radio (Land Mobile Radio system, amateur, two-way) ☐ Cellular (text, calls, data, pager, Wireless Priority Service) ☐ Satellite (phone, data) ☐ Other (free response)
PM13.2 Backup communication system used by the HCC during the first redundant communications drill	HCC	Drill notes or other operational documents	HCC Name:_____ (Select backup system) ☐ Telephone (landline, fax, Government Emergency Telecommunications Service) ☐ Internet (email, cable, fiber-optic, VOIP) ☐ Radio (Land Mobile Radio system, amateur, two-way) ☐ Cellular (text, calls, data, pager, Wireless Priority Service) ☐ Satellite (phone, data) ☐ Other (free response)
PM13.3 Total number of core member organizations responding to the first redundant communications drill	HCC	Drill notes or other operational documents	HCC Name:_____ # _____ (organizations)

Data Point	Data Entity	Data Source	Response
PM13.4 Total number of additional member organizations responding to the first redundant communications drill	HCC	Drill notes or other operational documents	HCC Name:_____ # _____ (organizations)
PM13.5 Primary communication system used by the HCC during the second redundant communications drill	HCC	Drill notes or other operational documents	HCC Name:_____ (Select primary system) ☐ Telephone (landline, fax, Government Emergency Telecommunications Service) ☐ Internet (email, cable, fiber-optic, VOIP) ☐ Radio (Land Mobile Radio system, amateur, two-way) ☐ Cellular (text, calls, data, pager, Wireless Priority Service) ☐ Satellite (phone, data) ☐ Other (free response)
PM13.6 Backup communication system used by the HCC during the second redundant communications drill	HCC	Drill notes or other operational documents	HCC Name:_____ (Select backup system) ☐ Telephone (landline, fax, Government Emergency Telecommunications Service) ☐ Internet (email, cable, fiber-optic, VOIP) ☐ Radio (Land Mobile Radio system, amateur, two-way) ☐ Cellular (text, calls, data, pager, Wireless Priority Service) ☐ Satellite (phone, data) ☐ Other (free response)
PM13.7 Total number of core member organizations responding to the second redundant communications drill	HCC	Drill notes or other operational documents	HCC Name:_____ # _____ (organizations)
PM13.8 Total number of additional member organizations responding to the second redundant communications drill	HCC	Drill notes or other operational documents	HCC Name:_____ # _____ (organizations)

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 Government Emergency Telecommunications Service (GETS); the only charge for GETS is usage.[6]

- **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. Land Mobile Radio (LMR) systems typically consist of handheld portable radios, mobile radios, base stations, a network, and repeaters.[7]
- **Responded:** The number of HCC member organizations that have actively confirmed receipt of the HCC's drill communication.
- **Redundant communications drill:** Please refer to the definition in the 2019 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; and others).

[6] "Government Emergency Telecommunications Service (GETS)." *Department of Homeland Security.* https://www.dhs.gov/government-emergency-telecommunications-service-gets. Accessed 6 Aug. 2020.
[7] "Land Mobile Radio (LMR) 101." *Department of Homeland Security.* https://www.cisa.gov/sites/default/files/publications/LMR%20101_508FINAL_0_0.pdf. Accessed 6 Aug. 2020.

Section 3: Medical Response and Surge Exercise Performance Measures

This section contains PMs that use data produced during the annual MRSE. For a crosswalk of PMs to the *2017-2022 Health Care Preparedness and Response Capabilities*, see Appendix 3: Crosswalk of Performance Measures to 2017-2022 Health Care Preparedness and Response Capabilities.

In FY 2021, ASPR created the Medical Response and Surge Exercise (MRSE) which officially replaces both the Coalition Surge Test (CST) and the Hospital Surge Test (HST). **The MRSE must be conducted at least once by each HCC by the end of FY 2022. In accordance with guidance provided throughout the budget year, as of HPP Budget Year 3 (July 1, 2021, to June 30, 2022), HCCs must complete the Medical Response and Surge Exercise (MRSE) annually. In FY 2021, in recognition of the ongoing challenges presented to health care by the COVID-19 pandemic, ASPR allowed HCCs to conduct the MRSE in either FY 2021 or in FY 2022.**

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 extent to which HCCs can coordinate to respond to a medical surge incident. In aggregate, these eight PMs enable greater understanding of HCCs' preparedness capacities.

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

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

The definitions for the PM types are:

- **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.

Medical Response and Surge Exercise

The MRSE captures information on HCC performance that directly informs the PMs. The MRSE tests a coalition's ability to work in a coordinated way, using their own systems and plans to find appropriate destinations, beds, and resources for patients by using a simulated medical surge event (that collectively represent at least 20 percent of a coalition's staffed acute care bed capacity). The detailed MRSE Situation Manual and Evaluation Plan can be viewed online. Please note that the MRSE Exercise Planning and Evaluation Tool is available on the Coalition Assessment Tool (CAT).

If an HCC has a real-world incident with a medical surge component that is equal to or greater than 20% of the required bed types and other scenario-specific bed types used in the MRSE, during the

performance year, the HCC can use the data from the real-world incident to respond to each applicable PM. If a real-world incident occurs during the reporting year, the HCC is still required to an AAR/IP.

The MRSE has no low- to no-notice requirement for the exercise. During the exercise planning phase, HCCs will determine exercise roles, understand members' specific needs from the exercise, define their surge scenario, and begin to enter planning and scoping data in the Exercise Planning and Evaluation Tool. By the end of this phase, the scenario, objectives (beyond those mandated by HPP), and desired outcomes for the exercise will be clearly defined and scheduled for a specific future date. Note, although there is no requirement for low- or no-notice format of the exercise, HCCs are encouraged to consider this option to mimic a real-world incident. The exercise is intended to be challenging and stress the overall surge capacity of the HCC; it is expected that most HCCs will not be able to complete all tasks fully. Pushing such stresses on the community health system is important for testing the HCC's current response systems, identifying gaps in preparedness, and informing improvement planning. HCCs will select their own peer assessors who can provide exacting, but constructive, feedback to improve response.

Because the exercise simulates a medical surge incident, it can reveal preparedness capabilities needed for several different scenarios. These capabilities may include emergency operations coordination, information sharing, and medical surge capacity among others.

The MRSE functional exercise includes the following three phases:

- **Phase 1: Plan & Scope**
  This phase should begin well in advance of the beginning of the actual exercise. In this phase, HCCs determine exercise roles, understand members' specific needs from the exercise, define their surge scenario, and begin to enter planning and scoping data in the Exercise Planning and Evaluation Tool. By the end of this phase, the scenario, objectives (beyond those mandated by HPP), and desired outcomes for the exercise will be clearly defined and scheduled for a specific future date. Note although there is no requirement for low- or no-notice format of the exercise, HCCs are encouraged to consider this option to mimic a real-world incident.
- **Phase 2: Exercise Operations**
  This phase begins when the Exercise Facilitator kicks off the exercise on the scheduled day. This phase largely follows the standard response actions included in the Health Care Coalition Response Plan or other jurisdictional response plan. The participants can consult the Situation Manual, but the Exercise Planning and Evaluation Tool will guide the Exercise Facilitator and Evaluator through the exercise actions and provide guidance for data collection required at each step.
- **Phase 3: Review (After-Action Discussion and Improvement Planning)**
  Key findings are documented through the After-Action Review (AAR) which outlines participant discussion topics, highlighting strengths, areas for improvement, decisions, and recommendations identified by participants during the exercise. The AAR can identify gaps in: (i) existing resources, roles, and responsibilities, (ii) notification and activation procedures, and (iii) information sharing coordination processes and protocols. It can also capture courses of action and specific resources necessary to implement response activities. The HCC should follow the AAR by creating an Improvement Plan (IP).

ASPR will use measures within the MRSE to assess achievement of preparedness goals for the health care system. Pursuant to Section 319C-1(g)(5) of the Public Health Service Act, failure to achieve this benchmark for one of two consecutive years may result in withholding of 10 percent of funding amounts and increased withholding amounts in subsequent years that this benchmark is not met.

Performance Measure 14

Percent of contacted HCC members acknowledging initial emergency notification

Goal or Target

ASPR will establish a baseline for the participation of additional members based on performance data collected in the initial fiscal years, which will be used to set targets and goals for subsequent years.

Operational Intent

This measure provides insight into communication among HCC members during a simulated or real medical surge event.

Data Reporting

Each HCC must report the following data in the Exercise Planning and Evaluation Tool and the CAT. During the specified time period for end-of-year reporting, recipients must enter this information on behalf of each HCC into the end-of-year performance measure module in PERFORMS.

Data Point	Data Entity	Data Source	Response
PM14.1 Number of HCC members acknowledging initial emergency notification	HCC	Exercise Planning and Evaluation Tool	HCC Name:_____ # _____ (Facilities)
PM14.2 Total number of HCC members contacted with initial emergency notification	HCC	Exercise Planning and Evaluation Tool	HCC Name:_____ # _____ (Facilities)

Definitions and Interpretation

- **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.
- **Acknowledged**: When a member organization has recognized a notification that has been sent out to the health care coalition.
- **Initial Emergency Notification**: The first emergency notification sent to members; and members are requested to acknowledge and respond to the notification by a deadline determined by the HCC.
- **Exercise Planning and Evaluation Tool:** The Excel-based tool is used primarily by the Exercise Evaluator to document decisions and results throughout the exercise, including the *Phase I: Plan & Scope* and *Phase III: Review*. The tool includes sequentially organized tabs that may be viewed by clicking on each tab's name at the bottom of the screen. All required exercise data collection – including data for HPP Cooperative Agreement performance measures – should be completed in the Exercise Planning and Evaluation Tool.

Performance Measure 15

Percent of contacted HCC members who responded to the initial information request

Goal or Target

ASPR will establish a baseline for the participation of additional members based on performance data collected in the initial fiscal years, which will be used to set targets and goals for subsequent years.

Operational Intent

This measure provides insight into communication among HCC members during a simulated or real medical surge event.

Data Reporting

Each HCC must report the following data into the Exercise Planning and Evaluation Tool and the CAT. During the specified time period for end-of-year reporting, recipients must enter this information on behalf of each HCC into the end-of-year performance measure module in PERFORMS. ASPR will calculate percentages.

Data Point	Data Entity	Data Source	Response
PM15.1 Number of HCC members who responded to an initial information request	HCC	Exercise Planning and Evaluation Tool	HCC Name:_____ # _____ (facilities)
PM15.2 Total number of HCC members contacted with an initial information request	HCC	Exercise Planning and Evaluation Tool	HCC Name:_____ # _____ (facilities)

Definitions and Interpretation

- **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.
- **Acknowledged**: When a member organization has recognized an information request that has been sent out to the health care coalition.
- **Initial Information Request**: The first request for information sent to member organizations that is acknowledged by a deadline determined by the HCC.
- **Responded**: When a member organization sends a message to confirm receipt of the initial information request.
- **Contacted**: Member organizations that have received communication about an initial information request.
- **Exercise Planning and Evaluation Tool**: The Excel-based tool is used primarily by the Exercise Evaluator to document decisions and results throughout the exercise, including the *Phase I: Plan & Scope* and *Phase III: Review*. The tool includes sequentially organized tabs that may be viewed by clicking on each tab's name at the bottom of the screen. All required exercise data collection – including data for HPP Cooperative Agreement performance measures – should be completed in the Exercise Planning and Evaluation Tool.

Performance Measure 16

Percent of all pre-identified, critical required personnel types that were met by participating HCC members to manage patient surge

Goal or Target

ASPR will establish a baseline for the participation of additional members based on performance data collected in the initial fiscal years, which will be used to set targets and goals for subsequent years.

Operational Intent

This measure provides insight into an HCC's ability to provide sufficient personnel support to appropriately respond to a simulated or real medical surge event.

Data Reporting

Each HCC must report the following data into the Exercise Planning and Evaluation Tool and the CAT. During the specified time period for end-of-year reporting, recipients must enter this information on behalf of each HCC into the end-of-year performance measure module in PERFORMS. ASPR will calculate percentages.

Data Point	Data Entity	Data Source	Response
PM16.1 Number of pre-identified, critical required personnel types that were met by participating HCC members to manage patient surge	HCC	Exercise Planning and Evaluation Tool	Facility Name:_____ #_____(Pre-identified critical required personnel types)
PM16.2 Total number of pre-identified, critical required personnel types	HCC	Exercise Planning and Evaluation Tool	HCC Facility:_____ #_____(Pre-identified critical required personnel types)

Definitions and Interpretation

- **Pre-identified**: Required for the scenario as defined by the HCC during *Phase I: Plan & Scope* and include personnel, pharmaceuticals supplies, and equipment.
- **Critical**: To be of decisive importance in respect to the chosen exercise scenario.
- **Personnel types**: Persons employed in an organization or place of work with different types of specialized skills that are useful for the chosen exercise scenario.
- **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.
- **Met**: Successfully acquired or satisfied a need.
- **Exercise Planning and Evaluation Tool**: The Excel-based tool is used primarily by the Exercise Evaluator to document decisions and results throughout the exercise, including the *Phase I: Plan & Scope* and *Phase III: Review*. The tool includes sequentially organized tabs that may be viewed by clicking on each tab's name at the bottom of the screen. All required exercise data collection – including data for HPP Cooperative Agreement performance measures – should be completed in the Exercise Planning and Evaluation Tool.

Performance Measure 17

Percent of all pre-identified, critical resources that were met to manage patient surge

Goal or Target

ASPR will establish a baseline for the participation of additional members based on performance data collected in the initial fiscal years, which will be used to set targets and goals for subsequent years.

Operational Intent

This measure provides insight into an HCC's ability to provide sufficient critical resources (e.g., supplies equipment, etc.) to appropriately respond to a simulated or real medical surge event.

Data Reporting

Each HCC should report the following data into the Exercise Planning and Evaluation Tool and the CAT. During the specified time period for end-of-year reporting, recipients must enter this information on behalf of each HCC into the end-of-year performance measure module in PERFORMS. ASPR will calculate percentages.

Data Point	Data Entity	Data Source	Response
PM17.1 Number of pre-identified, critical required resource types that were met by participating HCC members to manage patient surge	HCC	Exercise Planning and Evaluation Tool	Facility Name:_____ #: _____(Required, pre-identified, critical resources (critical + optional staffed beds, pharmaceutical supplies, and equipment type)
PM 17.2 Total number of pre-identified, critical required resource types	HCC	Exercise Planning and Evaluation Tool	Facility Name:_____ #: _____(Required, pre-identified, critical resources (critical + optional staffed beds, pharmaceutical supplies, and equipment type)

Definitions and Interpretation

- **Pre-identified**: Required for the scenario as defined by the HCC during *Phase I: Plan & Scope* and include personnel, pharmaceuticals supplies, and equipment.
- **Critical**: To be of decisive importance in respect to the chosen exercise scenario.
- **Resource types**: Available materials that are useful for the chosen exercise scenario.
- **Met**: Successfully acquired or satisfied a resource need**.**
- **Exercise Planning and Evaluation Tool**: The Excel-based tool is used primarily by the Exercise Evaluator to document decisions and results throughout the exercise, including the *Phase I: Plan & Scope* and *Phase III: Review*. The tool includes sequentially organized tabs that may be viewed by clicking on each tab's name at the bottom of the screen. All required exercise data collection – including data for HPP Cooperative Agreement performance measures – should be completed in the Exercise Planning and Evaluation Tool.

Performance Measure 18

Percent of all pre-identified, critical EMS resources that were met to safely respond to triage and transportation needs

Goal or Target

ASPR will establish a baseline for the participation of additional members based on performance data collected in the initial fiscal years, which will be used to set targets and goals for subsequent years.

Operational Intent

This measure provides insight into an HCC's ability to provide sufficient EMS resources to appropriately respond to a simulated or real medical surge event.

Data Reporting

Each HCC must report the following data into the Exercise Planning and Evaluation Tool and the CAT. During the specified time period for end-of-year reporting, recipients must enter this information on behalf of each HCC into the end-of-year performance measure module in PERFORMS. ASPR will calculate percentages.

Data Point	Data Entity	Data Source	Response
PM18.1 Number of pre-identified, critical EMS resource types that were met to safely respond to triage and transportation needs	HCC	Exercise Planning and Evaluation Tool	Facility Name:_____ #_____(Pre-identified, critical EMS resource types (personnel, transport, supplies & equipment)
PM18.2 Total number of pre-identified, critical EMS resource types	HCC	Exercise Planning and Evaluation Tool	Facility Name: ____ #_____ (Pre-identified, critical EMS resource types (personnel, transport, supplies & equipment)

Definitions and Interpretation

- **Pre-identified**: Required for the scenario as defined by the HCC during *Phase I: Plan & Scope* and include personnel, pharmaceuticals supplies, and equipment.
- **Critical**: To be of decisive importance in respect to the chosen exercise scenario.
- **Emergency Medical Services (EMS) Resource types**: Emergency Medical Services materials that are useful for the chosen exercise scenario.
- **Met**: Successfully acquired or satisfied a resource need**.**

- **Exercise Planning and Evaluation Tool**: The Excel-based tool is used primarily by the Exercise Evaluator to document decisions and results throughout the exercise, including the *Phase I: Plan & Scope* and *Phase III: Review*. The tool includes sequentially organized tabs that may be viewed by clicking on each tab's name at the bottom of the screen. All required exercise data collection – including data for HPP Cooperative Agreement performance measures – should be completed in the Exercise Planning and Evaluation Tool.

Performance Measure 19

Percent of patients requiring inpatient care who were placed at a receiving facility with an appropriate staffed bed by the end of the exercise

Goal or Target

ASPR will establish a baseline for the participation of additional members based on performance data collected in the initial fiscal years, which will be used to set targets and goals for subsequent years.

Operational Intent

This measure demonstrates the ability of an HCC to load share to meet initial patient care needs in a simulated or real medical surge event.

Data Reporting

Each HCC must report the following data into the Exercise Planning and Evaluation Tool and the CAT. During the specified time period for end-of-year reporting, recipients must enter this information on behalf of each HCC into the end-of-year performance measure module in PERFORMS. ASPR will calculate percentages.

Data Point	Data Entity	Data Source	Response
PM19.1 Number of surge patients and existing patients requiring admission for inpatient care with an appropriate, staffed bed after patients are discharged	HCC	Exercise Planning and Evaluation Tool	Facility Name:_____ #: _____(Patients)
PM19.2 The number of patients for whom you were unable to find an appropriate, staffed bed at a receiving facility and/or appropriate transport	HCC	Exercise Planning and Evaluation Tool	Facility Name:_____ #: _____(Patients)
PM19.3 Number of surge patients and existing patients requiring admission for inpatient care with an appropriate, staffed bed at the end of the exercise	HCC	Exercise Planning and Evaluation Tool	Facility Name:_____ #: _____(Patients)

Definitions and Interpretation

- **Staffed beds**: Beds that are licensed, physically available and staffed to attend to patients who occupy those beds. It includes only beds that are vacant. 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.
- **Discharged**: Patients that are released from a facility when they no longer need to receive inpatient care.
- **Inpatient**: Care provided to a patient in a hospital or other type of inpatient facility, where they are admitted, and spend at least one night or more, depending on their condition.
- **Receiving Facility**: Receiving facilities are all facilities that can receive patients.
- **Appropriate Transport**: Transportation provided to patients that need to be moved to a receiving facility. "Appropriate" refers to the clinically appropriate decision that is based on the patient's specific health care needs.
- **Requiring Admission**: Patients that need to enter a hospital as a patient based on their health needs.
- **Exercise Planning and Evaluation Tool**: The Excel-based tool is used primarily by the Exercise Evaluator to document decisions and results throughout the exercise, including the *Phase I: Plan & Scope* and *Phase III: Review*. The tool includes sequentially organized tabs that may be viewed by clicking on each tab's name at the bottom of the screen. All required exercise data collection – including data for HPP Cooperative Agreement performance measures – should be completed in the Exercise Planning and Evaluation Tool.

Performance Measure 20

Percent of HCC core members with at least one executive participating in the exercise After-Action Review (AAR)

Goal or Target

ASPR will establish a baseline for the participation of additional members based on performance data collected in the initial fiscal years, which will be used to set targets and goals for subsequent years.

Operational Intent

This measure 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 must report the following data into the Exercise Planning and Evaluation Tool and the CAT. During the specified time period for end-of-year reporting, recipients must enter this information on behalf of each HCC into the end-of-year performance measure module in PERFORMS. ASPR will calculate percentages.

Data Point	Data Entity	Data Source	Response
PM20.1 Number of HCC core members with at least one executive participating in the exercise After-Action Review (AAR)	HCC	Exercise Planning and Evaluation Tool	Facility Name:_____ #_____(HCC core members with at least one executive participating in the AAR)
PM20.2 Total number of HCC core members participating in the exercise After-Action Review (AAR).	HCC	Exercise Planning and Evaluation Tool	Facility Name: ____ #_____ (HCC core members)

Definitions and Interpretation

- **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.
- **Executives:** An executive is a decision-maker for his/her respective organization and must have decision-making power that includes, but is 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**: Attending and contributing to an event, whether in person or remotely.
- **AAR/IP:** An 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 HSEEP principles, and HPP will provide an optional template for future use.[8]

Performance Measure 21

Percent of all pre-identified, critical HCC members that participated in the exercise

Goal or Target

ASPR will establish a baseline for the participation of additional members based on performance data collected in the initial fiscal years, which will be used to set targets and goals for subsequent years.

[8] "Phase 4: After Action Report and Improvement Planning." *City and County of San Francisco Department of Emergency Management*. h_ttp://sfdem.org/phase-4-after-action-report-and-improvement-planning-0. Accessed 6 Aug. 2020.

Operational Intent

Participation of HCC members crucial to truly test preparedness and response capabilities. Thus, this measure is intended to gauge the extent to which HCC core member organizations are engaged in coalition exercises.

Data Reporting

Each HCC must report the following data into the Exercise Planning and Evaluation Tool and the CAT. During the specified period for end-of-year reporting, recipients must enter this information on behalf of each HCC into the end-of-year performance measure module in PERFORMS. ASPR will calculate percentages.

Data Point	Data Entity	Data Source	Response
PM21.1 Number of all pre-identified, critical HCC members that participated in the exercise	HCC	Exercise Planning and Evaluation Tool	Facility Name:_____ #: _____(pre-identified, critical HCC members)
PM21.2 Total number of pre-identified, critical HCC members	HCC	Exercise Planning and Evaluation Tool	Facility Name:_____ #: _____(pre-identified, critical HCC members)

Definitions and Interpretation

- **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.
- **Pre-identified**: Required for the scenario as defined by the HCC during *Phase I: Plan & Scope* and include personnel, pharmaceuticals supplies, and equipment.
- **Critical**: To be of decisive importance in respect to the chosen exercise scenario.
- **Participated**: Individuals who joined and played a pivotal role in the exercise.
- **AAR/IP:** An 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 HSEEP principles, and HPP will provide an optional template for future use.[9]

[9] "Phase 4: After Action Report and Improvement Planning." *City and County of San Francisco Department of Emergency Management*. http://sfdem.org/phase-4-after-action-report-and-improvement-planning-0. Accessed 6 Aug. 2020.

Section 4: Joint Performance Measures

This section contains joint PMs between HPP and other programs, including HRSA's Emergency Medical Services for Children (EMSC) and the Centers for Disease Control and Prevention's (CDC) Public Health Emergency Preparedness (PHEP) program. 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 3: Crosswalk of Performance Measures to 2017-2022 Health Care Preparedness and Response Capabilities.

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

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

PM	Data Entity	PM Type
22	Hospital	Activity
HPP-PHEP J.1	Recipient	Activity
HPP-PHEP J.2	Recipient	Activity

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

The measure is designed to 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 EMSC programs, highlighting pediatric readiness as key to ensuring that 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
PM22.1 Reported by EMSC: Hospitals with EDs that are able to stabilize and/or manage pediatric medical emergencies	Hospitals	EMSC[10]	N/A

Definitions and Interpretation

- **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.

Performance Measure HPP-PHEP J.1: Information Sharing

Percent of local partners that requested Essential Elements of Information to the public health/medical lead within the recipient's timeframe

Recipients 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 a medical countermeasures (MCM) incident or scenario (including an exercise or drill) will count towards the medical countermeasures Operational Readiness Review (MCM ORR), so make sure this is accomplished at least every other year. In alternate years, consider exercising information sharing related to non-MCM incidents and scenarios to test capabilities 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). *Recipients are required to report at least two data points for this measure.* One data point must reflect the recipient's best performance (highest percentage); the other

[10] 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 recipients, HCCs, and hospitals do not need to provide data to HPP for this component of the measure.

must reflect performance which, based on a determination from the recipient, calls for focused quality improvement and, if applicable, technical assistance. Recipients are encouraged to submit data on additional incidents, planned events, and exercises. 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 it 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 reported requested EEI to the public health/medical lead within the requested timeframe (numerator) *[Max five digits]*

   Performance Measure: Percent of local partners that reported EEI to the public health/medical lead within the requested timeframe (System calculated) *[Percentage]*
2. Number of local partners that received a request for EEI (denominator) *[Max five digits]*
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?
   - 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
    - Health care organizations (HCOs)
    - Local public health entities
9. Did "other" types of local partners (not listed above) respond to the request? *[Max five "other" types]*
    - No
    - Yes
        - 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
    - EMS status

- Epidemiological, surveillance, or lab data (e.g., test results, case counts, deaths)
- School-related data (e.g., closure, absenteeism)
- Point of Dispensing (POD)/mass vaccine sites data (e.g., throughout, open/set-up status)
- 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 (e.g., electronic bed or patient tracking, survey tools, Web-Based Emergency Operations Center [WebEOC] or similar)
    - Health Alert Network (HAN)
    - Other, please specify *[Max 100 characters]*
13. Continuous Quality Improvement:
    - Were relevant corrective action/improvement plan 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 action/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 ,000 characters]*

How is this measure operationalized?

This measure intends to capture information on the communication of incident-specific public health/medical EEI. Determination of which EEI 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 recipient to determine which of this information was "essential"—and therefore able to count towards the numerator and denominator—for this PM.

Key Measurement Terms

- **EEI:** EEI are discrete types of reportable public health or health care-related incident-specific knowledge that are communicated or received concerning a particular fact or circumstance; EEI are 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 are 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 that receive requests for EEI. Local partners may differ based on the type of incident/exercise/planned event (e.g., HCOs, local health departments, HCCs).
- **Requested timeframe:** Requested timeframe is a recipient-defined period of time for receiving requested EEI (e.g., operational period, set time to meet special request).
- **Responsible entity or entities:** A responsible entity (or entities) refers to an organization at the recipient or sub-recipient level that is accountable for completing the specific activity or element associated with one or more PHEP PMs.

Performance Measure HPP-PHEP J.2: Volunteer Management

Percent 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 that inhibit the 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 HCOs.

What other requirements are there for reporting measure data?

- Recipients may report the numerator and denominator of this measure *by incident or exercise* at the state, sub-state regional, or local level.
- *Recipients that experience two or more incidents or exercises* involving the deployment of volunteers must report on at least two of those.
    - One data point must reflect the recipient's best performance (highest percentage).
    - The other data point must reflect performance that, based on a determination from the recipient, calls for focused quality improvement and, if applicable, technical assistance
    - Recipients are encouraged to submit data on additional incidents and exercises as well. There are no specific reporting requirements or parameters for additional data points.
- *Recipients that experience only one incident or exercise* involving the deployment of volunteers must report on it.
- *Recipients that experience no incidents or exercises* involving the 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 volunteers 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 incidents or exercises involving actual deployment of volunteers occurred in the fiscal year.
- In future years, recipients may be required to exercise actual volunteer deployment if there are no volunteer deployments during a public health/medical incident in consecutive fiscal years.

How does this measure align with the Medical Countermeasures (MCM) Operational Readiness Review (ORR) tool?

While there are no direct links between HPP-PHEP J.1 and 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 fiscal year. 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, please enter the following information:

2. The number of volunteers who arrived at staging area/on scene within the requested timeframe (numerator) *[Max five digits]*

3. The number of volunteers determined to be needed for the response by the public health/medical lead or other authorized official (denominator) *[Max five digits]*
   Of these:
   a. Number of deployed volunteers registered in ESAR-VHP *[Max five digits]*
   b. Number of deployed volunteers registered in other systems *[Max five digits]*
   c. **Total** *(System Calculated) [Max five digits] (Note: Sum of 3a and 3b must equal value entered for Question 3)*

   Percent 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]*
   a. HPP Volunteer Management Capability[11]
   b. PHEP Volunteer Management Capability
   c. 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]*
   a. Local health department
   b. State health department
   c. Health care organization
   d. Health care coalition
   e. Other, please specify: [Max 100 characters]
10. The requested location for the deployment *[Select one]*

[11] Volunteer management has been incorporated into Capability 4: Medical Surge.

   a. Staging/assembly area(s) (not actual incident site)
   b. Hospital(s)
   c. Shelter(s)
   d. Point(s) of Dispensing (POD or PODs)
   e. Alternate care site(s), please specify [Max 750 characters]
   f. 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 volunteers to support a public health/medical incident within requested timeframe. *[Select all that apply]*
   a. Communication
   b. Equipment
   c. Funding
   d. Participation
   e. Policies/procedures
   f. Resource limitations
   g. Staffing
   h. Time constraints
   i. Training
   j. Other, please specify
   k. None
13. Continuous Quality Improvement:
   a. Were relevant corrective action/improvement plan 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
   b. Have corrective action/improvement plan items related to volunteer management been identified as a result of this incident/drill?
      - Yes
      - No
   c. Have they been implemented?
      - Yes
      - No
      - Some
14. *[Optional]* Please provide any additional clarifying, contextual, or other information. *[Max 1,000 characters]*
15. Recipients that experience no incidents or exercises involving the 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:
   a. Number of volunteers contacted (registered in the ESAR-VHP system) *[Max five digits]*
   b. Number of volunteers contacted (registered in other systems) *[Max five digits]*
   c. Number of volunteers in the ESAR-VHP system that acknowledged contact within the requested timeframe *[Max five digits]*
   d. Number of volunteers registered in other systems that acknowledged contact within the requested timeframe *[Max five digits]*
   e. 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.

Recipients 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, as 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 typically made by local response entities; it is a formal application (to the health and medical lead at the local, regional, or state level) to ask for a specified number of needed volunteers.
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 recipient or sub-recipient 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.)

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.[12]
Acknowledged	When a member organization has recognized a notification that has been sent out to the health care coalition.
Acute Care Hospital	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 (AAR/IP)	An 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]
Appropriate Transport	Transportation provided to patients that need to be moved to a receiving facility. "Appropriate" refers to the clinically appropriate decision that is based on the patient's specific health care needs.

[12] "At Risk Individuals." *Public Health Emergency*. http://www.phe.gov/Preparedness/planning/abc/Pages/atrisk.aspx. Accessed 7 Aug. 2020.

[13] "Phase 4: After Action Report and Improvement Planning." *City and County of San Francisco Department of Emergency Management*. http://sfdem.org/phase-4-after-action-report-and-improvement-planning-0. Accessed 7 Aug. 2020.

Term	Definition
CHEMPACK	The CHEMPACK program began as an initiative of CDC's Division of Strategic National Stockpile (SNS) in 1983 before oversight and operational control of the SNS and CHEMPACK moved to the Administration for Strategic Preparedness and Response (ASPR) in early 2018. It provides antidotes (three countermeasures used concomitantly) to nerve agents for pre-positioning by State, local, and/or tribal officials throughout the U.S.[14]
Coalition Assessment Tool (CAT)	The CAT is a simple, online form that will enable HCCs to complete a self- assessment of their current state against various HPP requirements, including HPP Performance Measures.
Coalition Surge Test (CST)	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, which 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.
Community Reception Center	A radiation incident affecting a large population will require local response authorities to establish one or more population monitoring and decontamination facilities to assess people for exposure, contamination, and the need for decontamination or other medical follow-up. These facilities are known as community reception centers.[15]
Contacted	Member organizations that have received communication about an initial information request.
Critical	To be of decisive importance in respect to the chosen exercise scenario.

[14] "Chemical Hazards Emergency Medical Management." *U.S. Department of Health and Human Services*. https://chemm.nlm.nih.gov/chempack.htm. Accessed 7 Aug. 2020.
[15] "Community Reception Center Electronic Data Collection Tool." *Centers for Disease Control and Prevention*. https://www.cdc.gov/nceh/radiation/emergencies/crcetool.htm. Accessed 7 Aug. 2020.

Term	Definition
Critical Care	Critical care helps people with life-threatening injuries and illnesses, including 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.[16]
Data Entity	For each PM, the organization(s) providing the data for the measure (recipient, HCC, or hospital) is listed.
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 are documented and managed (e.g., exercise materials, meeting notes, or financial statements). Data sources should be archived for future verification purposes.
Definitions and Interpretations	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.), as well as 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).[17]
Discharged	Patients that are released from a facility when they no longer need to receive inpatient care.

[16] "Critical Care." *MedlinePlus.* medlineplus.gov/criticalcare.html. Accessed 7 Aug. 2020.
[17] "ICDRM/GWU Emergency Management Glossary of Terms." *The George Washington University Institute for Crisis, Disaster, and Risk Management,* 30 Jun. 2010. pp. 30. PDF. http://www.calhospitalprepare.org/sites/main/files/file-attachments/glossary_-_emergency_management_icdrm_30_june_10.pdf. Accessed 7 Aug. 2020.

Term	Definition
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).[18]
Emergency Medical Services for Children (EMSC)	The EMSC program is administered by the Health Resources and Services Administration (HRSA). 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.
Emergency Medical Services (EMS) Resource types	Emergency Medical Services materials that are useful for the chosen exercise scenario.
Emergency Operations Center (EOC)	The physical location at which the coordination of information and resources to support incident management activities (on-scene operations) normally takes place. An EOC may be a temporary facility; it can also be located in a more central or permanently established facility, perhaps at a higher-level 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.[19]
Emergency Support Function-8 (ESF-8)	ESF-8 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[20]

[18] Ibid.
[19] Ibid.
[20] "Emergency Support Functions." *Public Health Emergency.* Accessed 7 Aug. 2020. 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.[21] Within the context of Emergency Support Functions (ESF), lead agencies have significant authorities, roles, resources, and capabilities for a particular function within an ESF.
Emergency Support Function-8 (ESF-8) Response Plan	The response plan that an entity (organization, jurisdiction, state, etc.) maintains, which describes its intended response to any emergency situation. The response plan, aligned with ESF-8,provides action guidance for management and emergency response personnel during the response phase.[22]
Essential Elements of Information (EEI)	EEI enable situational awareness of an incident or response.[23] EEI are discrete types of reportable public health or health care-related incident-specific knowledge that are communicated or received concerning a particular fact or circumstance; EEI are 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 are communicated to local partners as part of information collection request templates and emergency response playbooks.
Executives	An executive is a decision-maker for his/her respective organization and should have decision-making power that includes, but is 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.
Exercise Planning and Evaluation Tool	The Excel-based tool is used primarily by the Exercise Evaluator to document decisions and results throughout the exercise, including the *Phase I: Plan & Scope* and *Phase III: Review*. The tool includes sequentially organized tabs that may be viewed by clicking on each tab's name at the bottom of the screen. All required exercise data collection – including data for HPP Cooperative Agreement performance measures – will be completed in the Exercise Planning and Evaluation Tool.

[21] Ibid.
[22] Ibid.
[23] "Essential Elements of Information*." Public Health Emergency*. www.phe.gov/Preparedness/planning/playbooks/rdd/Pages/essentialelements.aspx. Accessed 7 Aug. 2020.

Term	Definition
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 initial fiscal years have been reviewed).
Health Care Coalition(s) (HCC)	A group of individual health care and response organizations (e.g., acute care hospitals, emergency medical services (EMS), emergency management agencies, 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 acute care 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 are be included in this definition.[24]
Hospital Surge Test (HST)	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 health care 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 make recurring tabletop exercises a reality by providing a fully-developed tabletop exercise that can be used at their facilities.

[24] "ICDRM/GWU Emergency Management Glossary of Terms." *The George Washington University Institute for Crisis, Disaster, and Risk Management,* 30 Jun. 2010. pp. 48. PDF. http://www.calhospitalprepare.org/sites/main/files/file-attachments/glossary_-_emergency_management_icdrm_30_june_10.pdf. Accessed 7 Aug. 2020.

Term	Definition
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.[25]
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.[26]
In-kind Support	• **In-kind support from sources other than the recipient:** Any non-monetary support for HCC activities received from sources other than the recipient. For further definitions of in-kind support, see 45 Code of Federal Regulation (CFR), Part 75 at https://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75. • **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.
Initial Information Request	The first request for information sent to member organizations that is acknowledged by a deadline determined by the HCC.
Inpatient	Care provided to a patient in a hospital or other type of inpatient facility, where they are admitted, and spend at least one night or more, depending on their condition.

[25] Hick, John L., et al. "Health Care Facility and Community Strategies for Patient Care Surge Capacity." *Annals of Emergency Medicine.* 15 Jul. 2004. PDF. https://pubmed.ncbi.nlm.nih.gov/15332068/. Accessed 7 Aug. 2020.
[26] "The National Incident Management System." *FEMA.* http://www.fema.gov/national-incident-management-system. Accessed 7 Aug. 2020.

Term	Definition
Jurisdictional Risk Assessment (JRA)	Recipients 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, which specifically relate to the public health, medical, and mental/behavioral systems and the functional needs of at-risk individuals.
Medical Response and Surge Exercise (MRSE)	The MRSE is a functional exercise, which HSEEP describes as "an operations-based exercise designed to test and evaluate capabilities and functions while in a realistic, real-time environment." The MRSE is designed to examine and evaluate the ability of HCCs and other stakeholders to support medical surge, and specifically, how coalitions help patients receive the care they need at the right place, at the right time, and with the right resources during medical surge; decrease deaths, injuries, and illnesses resulting from medical surge; and promote health care delivery system resilience in the aftermath of medical surge. The MRSE includes three phases. Phase One is the Plan & Scope Phase in which HCCs set up their specific surge scenario. In Phase Two (Exercise), the HCC completes the exercise. In Phase Three (Review), the HCC completes their After-Action Review and improvement planning process. The MRSE and related items are available online.
Member Type	A category of health care coalition (HCC) members that represents a type of facility or organization within one HCC (e.g., all nursing facilities, all acute care hospitals, or all emergency medical services (EMS) agencies).
Met	Successfully acquired or satisfied a need.
Notification	The first emergency notification sent to members; and members are requested to acknowledge and respond to the notification by a deadline determined by the HCC.
Operational Intent	A brief description of the purpose of each PM and its link to preparedness program priorities.
Participating	Attending and contributing to an event, whether in person or remotely.
PERFORMS	PERFORMS is the data collection system that recipients use for FY 2019 end of year data collection. The system is owned and hosted by CDC.
Personnel types	Persons employed in an organization or place of work with different types of specialized skills that are useful for the chosen exercise scenario.
Pre-identified	Required for the scenario as defined by the HCC during *Phase I: Plan & Scope* and include personnel, pharmaceuticals supplies, and equipment.

Term	Definition
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.
Receiving Facility	Receiving facilities are all facilities that are able to receive patients.
Requiring Admission	Patients that need to enter a hospital as a patient based on their health needs.
Resource types	Available materials that are useful for the chosen exercise scenario.
Responded	When a member organization sends a message to confirm receipt of the initial information request.
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.
Staffed Beds	Beds that are licensed, physically available and staffed to attend to patients who occupy those beds. It includes only beds that are vacant. 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.
Treatment Space	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.[27]

[27] "A Whole Community Approach to Emergency Management: Principles, Themes, and Pathways for Action." *FEMA*. Dec 2011. PDF. https://www.fema.gov/media-library-data/20130726-1813-25045-0649/whole_community_dec2011__2_.pdf. Accessed 7 Aug. 2020.

Appendix 1: 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 by considering different audiences and information needs, including national-level (Congress, HHS, partners), program-level (HPP, FPOs), and implementation-level (recipients, HCCs, and facilities);
- Align with revised *2017-2022 Health Care Preparedness and Response Capabilities;*
- Consider burden to recipients 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.

The Evaluation Branch, within the Office of Strategy, Planning, Policy, and Requirements (SPPR) (formerly the Science Healthcare Preparedness Evaluation and Research branch) 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: SPPR and HPP FPOs; recipients and HCCs; the ASPR At-Risk Individuals (ARI) program; congressional and press inquiries; and external partner working groups.

SPPR engaged the National Healthcare Preparedness Programs (NHPP) branch, HPP recipients and HCCs, and subject matter experts to develop the program's theory of change and these PMs. NHPP conducted a branch-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, SPPR identified every measurable concept in the capabilities for which HCCs are responsible and HPP intends to invest. Next, SPPR streamlined the draft measures to reflect burden considerations and other guiding principles. Through a period of open comment, SPPR engaged HPP recipients, HCCs, and national partners in a burden and feasibility review. Based on feedback from national engagement, SPPR refined the measures for inclusion in the FOA. Finally, to support the implementation of the PMs, SPPR developed this implementation guide and piloted the guide with a small number of recipients and HCCs that were recruited to provide detailed feedback on guidance language.

Appendix 2: 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:
  - Acute care hospitals (a minimum of two)
  - EMS (including inter-facility and other non-EMS patient transport systems)
  - Emergency management agencies
  - Public health agencies
- Additional HCC members include the following:
  - Behavioral health services and organizations
  - Community Emergency Response Team and Medical Reserve Corps
  - Dialysis centers and regional Centers for Medicare & Medicaid Services (CMS)-funded end-stage renal disease networks
  - 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, 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 services, faith-based organizations)
  - Specialty patient referral centers (e.g., pediatric, burn, trauma, and psychiatric centers)

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

Table 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 recipient, 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 the fiscal year for recipients to execute subawards with each HCC	• Capability 1 – Foundation for Health Care and Medical Readiness
PM3: Number of calendar days from the start of fiscal year for recipients to provide a detailed spend plan, including all budget line items, to all HCCs within their jurisdiction and any interested health care entity	• Capability 1 – Foundation for Health Care and Medical Readiness ▪ Objective 1 – Establish and Operationalize a Health Care Coalition
PM4: 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 Coalition ➢ Activity 1 – Define Health Care Coalition Boundaries ➢ Activity 2 – Identify Health Care Coalition Members
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: Percent of HCCs that have a complete and approved response plan annex addressing the required annual specialty surge requirement: • FY 2019 – Pediatric • FY 2020 – Burn or Infectious Disease • FY 2021 – Burn or Infectious disease • FY 2022 – Radiation • FY 2023 – Chemical	• Capability 2 – Health Care and Medical Response Coordination ▪ Objective 1 – Develop and Coordinate Health Organization and Health Care Coalition Response Plans ➢ Activity 2 – Develop a Health Care Coalition Response Plan • Capability 4 – Medical Surge ▪ Objective 1 – Plan for a Medical Surge ➢ Activity 3 – Incorporate Medical Surge into a Health Care Coalition Response Plan ➢ Activity 4 – Provide Pediatric Care during a Medical Surge ➢ Activity 5 – Provide Surge Management during a Chemical or Radiation Emergency Event ➢ Activity 6 – Provide Burn Care during a Medical Surge Response ➢ Activity 9 – Enhance Infectious Disease Preparedness and Surge Response
PM7, Part A: Percent of *recipients* that access the de-identified emPOWER data map at least once every six months to identify the number of individuals with electricity-dependent medical and assistive equipment for planning purposes PM7, Part B: Percent of *HCCs* that obtain the de-identified emPOWER data map at least once every six months to identify the number 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 * AS, CNMI, and USVI territories must also report. No other territories must report.
PM8: Percent of recipients that have provided an opportunity for each HCC to review and provide input to the recipient's ESF-8 response plan	• Capability 1 – Foundation for Health Care and Medical Readiness ▪ Objective 1 – Establish and Operationalize a Health Care Coalition ➢ Activity 3 – Establish Health Care Coalition Governance

PM Description	Capability
PM9: Percent of HCCs engaged in their recipient'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' 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 • 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
PM11: Percent of recipients with a complete, jurisdiction-wide CONOPS that delineates: a) the roles and responsibilities of state agencies during a crisis care situation, b) potential indicators and triggers for state actions, c) actions the state will take to support prolonged crisis care conditions that cannot be rapidly addressed through standard mutual aid or other mechanisms, d) operational framework for state-level information management and policy development, e) legal and regulatory state actions that may be taken, f) actions state will take to comply with federal nondiscrimination laws, and g) actions state will take to engage the community and clinicians for crisis care planning and decision making	• 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

PM Description	Capability
PM12: Percent of HCCs that have drilled their primary communications plan and system/platform and one redundant communications system/platform (not connected to the commercial power grid) 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 contacted HCC members acknowledging initial emergency notification	• Capability 2 – Health Care and Medical Response Coordination ▪ Objective 2 – Utilize Information Sharing Procedures and Platforms ➢ Activity 3 – Utilize Communications Systems and Platforms • Capability 4 – Medical Surge ▪ Objective 2 – Respond to a Medical Surge ➢ Activity 1 – Implement Emergency Department and Inpatient Medical Surge Response
PM15: Percent of contacted HCC members who responded to the initial information request	• Capability 2 – Health Care and Medical Response Coordination ▪ Objective 2 – Utilize Information Sharing Procedures and Platforms ➢ Activity 3 – Utilize Communications Systems and Platforms • Capability 4 – Medical Surge ▪ Objective 2 – Respond to a Medical Surge ➢ Activity 1 – Implement Emergency Department and Inpatient Medical Surge Response
PM16: Percent of all pre-identified, critical required personnel types that were met by participating HCC members to manage patient surge	• Capability 1 – Foundation for Health Care and Medical Readiness ▪ Objective 4 – Train and Prepare the Health Care and Medical Workforce ➢ Activity 3 – Plan and Conduct Coordinated Exercises with Health Care Coalition Members and Other Response Organizations • Capability 2 – Health Care and Medical Response Coordination ▪ Objective 2 – Utilize Information Sharing Procedures and Platforms ➢ Activity 3 – Utilize Communications Systems and Platforms

PM Description	Capability
	▪ Objective 3 – Coordinate Response Strategy, Resources, and Communications ➢ Activity 1 – Identify and Coordinate Resource Needs during an Emergency ➢ Activity 3 – Communicate with Health Care Providers, Non-Clinical Staff, Patients, and Visitors during an Emergency • Capability 4 – Medical Surge ▪ Objective 2 – Response to a Medical Surge ➢ Activity 1 – Implement Emergency Department and Inpatient Medical Surge Response
PM17: Percent of all pre-identified, critical resources that were met to manage patient surge	• Capability 1 – Foundation for Health Care and Medical Readiness ▪ Objective 4 – Train and Prepare the Health Care and Medical Workforce ➢ Activity 3 – Plan and Conduct Coordinated Exercises with Health Care Coalition Members and Other Response Organizations • Capability 2 – Health Care and Medical Response Coordination ▪ Objective 2 – Utilize Information Sharing Procedures and Platforms ➢ Activity 3 – Utilize Communications Systems and Platforms ▪ Objective 3 – Coordinate Response Strategy, Resources, and Communications ➢ Activity 1 – Identify and Coordinate Resource Needs during an Emergency ➢ Activity 3 – Communicate with Health Care Providers, Non-Clinical Staff, Patients, and Visitors during an Emergency • Capability 3 – Continuity of Health Care Service Delivery ▪ Objective 3 – Maintain Access to Non-Personnel Resources during an Emergency ➢ Activity 2 – Assess and Address Equipment, Supply, and Pharmaceutical Requirements • Capability 4 – Medical Surge ▪ Objective 2 – Response to a Medical Surge ➢ Activity 1 – Implement Emergency Department and Inpatient Medical Surge Response ➢ Activity 2 – Implement Out-of-Hospital Medical Surge Response

PM Description	Capability
PM18: Percent of all pre-identified, critical EMS resources that were met to safely respond to triage and transportation needs	• Capability 1 – Foundation for Health Care and Medical Readiness ▪ Objective 4 – Train and Prepare the Health Care and Medical Workforce ➢ Activity 3 – Plan and Conduct Coordinated Exercises with Health Care Coalition Members and Other Response Organizations • Capability 2 – Health Care and Medical Response Coordination ▪ Objective 2 – Utilize Information Sharing Procedures and Platforms ➢ Activity 3 – Utilize Communications Systems and Platforms ▪ Objective 3 – Coordinate Response Strategy, Resources, and Communications ➢ Activity 1 – Identify and Coordinate Resource Needs during an Emergency ➢ Activity 3 – Communicate with Health Care Providers, Non-Clinical Staff, Patients, and Visitors during an Emergency • Capability 3 – Continuity of Health Care Delivery ▪ Objective 6 – Plan for and coordinate Health Care Evacuation and Relocation ➢ Activity 2 – Develop and Implement Evacuation Transportation Plans
PM19: Percent of patients requiring inpatient care who were placed at a receiving facility with an appropriate staffed bed by the end of the exercise	• 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 ➢ Activity 2 – Develop and Implement Evacuation Transportation Plans • Capability 4 – Medical Surge ▪ Objective 2 – Respond to a Medical Surge ➢ Activity 1 – Implement Emergency Department and Inpatient Medical Surge
PM20: Percent of HCC core members with at least one executive participating in the exercise After-Action Review (AAR)	• Capability 1 – Foundation for Health Care and Medical Readiness ▪ Objective 4 – Train and Prepare the Health Care and Medical Workforce ➢ Activity 2 – Educate and Train on Identified Preparedness and Response Gaps ➢ Activity 5 – Evaluate Exercises and Responses to Emergencies ➢ Activity 6 – Share Leading Practices and Lessons Learned ▪ Objective 5 – Ensure Preparedness is Sustainable ➢ Activity 2 – Engage Health Care Executives

PM Description	Capability
PM21: Percent of all pre-identified, critical HCC members that participated in the exercise	• Capability 1 – Foundation for Health Care and Medical Readiness ▪ Objective 1 – Establish and Operationalize a Health Care Coalition ➢ 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 and Other Response Organizations
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

Appendix 4: Required Components of a Response Plan

A complete response plan has all of the required components identified in the FOA as well as in the *2017-2022 Health Care Preparedness and Response Capabilities.* HCCs may elect to address the components associated with the response plan in two separate documents or in multiple documents; however, all components must be documented.

Required Components of a Response Plan

Each HCC funded by the recipient **must** develop a response plan that is informed by its members' individual emergency operations plans and submit the plan to ASPR 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, acute care hospitals, EMS, emergency management agencies, and public health agencies are represented in the plan. Each HCC **must** review and update its response plan regularly, as well as 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:

- HCC integration with the jurisdiction's ESF-8 lead agency to ensure information is provided to local, state, and federal officials.
- The HCC's ability to effectively communicate and address resource needs requiring ESF-8 assistance. In cases where the HCC serves as the jurisdiction's ESF-8 lead agency, the HCC response plan may be the same as the ESF-8 response plan.
- The HCC's ability to support the increase of emergency and inpatient services to meet the demands of a medical surge event (with or without warning; short or long duration). All communities should be prepared to respond to conventional and mass violence trauma.
- The HCC's ability to determine bed, staffing, and resource availability; identify patient movement requirements; support acute care patient management and throughput; initiate and support crisis care plans.
- The provision of behavioral health support and services to patients, families, responders, and staff.
- The incorporation of available resources for management of mass fatalities through ESF-8.

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*.

Required Components of a Specialty Surge Annex

HCCs **must** provide a complete and approved response plan annex addressing the required annual Specialty Surge requirement. HCCs **must** include a draft response plan annex addressing pediatric surge completed and uploaded into the CAT. Final plans **must** be submitted with the FY 2019 Annual Progress Report (APR).

HCCs **must** develop complementary, coalition-level annexes to their base medical surge/trauma mass casualty response plan(s) to manage a large number of casualties with specific needs. Recipients should incorporate the HCC annexes into their jurisdiction's plan for awareness and to support coordination of state resources. In addition to the usual information management and resource coordination functions, each specialty surge annex framework should be similarly formatted and emphasize the following core elements:

- Indicators/triggers and alerting/notifications of a specialty event
- Initial coordination mechanism and information gathering to determine impact and specialty needs
- Documentation of available local, state, and interstate resources that can support the specialty response and key resource gaps that may require external support (including inpatient and outpatient resources)
- Access to subject matter experts – local, regional, and national
- Prioritization method for specialty patient transfers (e.g., which patients are most suited for transfer to a specialty facility)
- Relevant baseline or just-in-time training to support specialty care
- Evaluation and exercise plan for the specialty function

In addition to the general requirements above, the specialty surge annex must address additional factors for each of the specialties listed below (depending upon which is exercised which year):

- Pediatric (FY 2019)
    - Local risks for pediatric-specific mass casualty events (e.g., schools, transportation accidents)
    - Age-appropriate medical supplies
    - Mental health and age-appropriate support resources
    - Pediatric/Neonatal Intensive Care Unit (NICU) evacuation resources and coalition plan
    - Coordination mechanisms with dedicated children's hospital(s)
- Burn (FY 2020 or 2021)[28]
    - Local risks for mass burn events (e.g., pipelines, industrial, terrorist, transportation accidents)
    - Burn-specific medical supplies
    - Coordination mechanisms with American Burn Association (ABA) centers/region
    - Incorporation of critical care air/ground assets suitable for burn patient transfer
- Infectious Disease (FY 2020 or 2021)[29]

[28] Due to the Coronavirus Disease 2019 (COVID-19), HCCs must develop either the Burn Care Surge Annex or the Infectious Disease Preparedness and Surge Annex in FY 2020 and must develop the other in FY 2021

[29] Due to the Coronavirus Disease 2019 (COVID-19), HCCs must develop either the Burn Care Surge Annex or the Infectious Disease Preparedness and Surge Annex in FY 2020 and must develop the other in FY 2021

  - Expanding existing Ebola concept of operations (CONOPS) plans to enhance preparedness and response for all novel/high consequence infectious diseases
  - Developing coalition-level anthrax response plans
  - Developing coalition-level pandemic response plans
  - Including healthcare-associated infection (HAI) professionals at the health care facility and jurisdictional levels in planning, training, and exercises/drills
  - Developing a continuous screening process for acute care patients and integrate information with electronic health records (EHRs) where possible in HCC member facilities and organizations
  - Coordinating visitor policies for infectious disease emergencies at member facilities to ensure uniformity
  - Coordinating medical countermeasures (MCM) distribution and use by health care facilities for prophylaxis and acute patient treatment
  - Developing and exercising plans to coordinate patient distribution for highly pathogenic respiratory viruses and other highly transmissible infections, including complicated and critically ill infectious disease patients, when tertiary care facilities or designated facilities are not available
- Radiation (FY 2022)
  - Local risks for radiation mass casualty events (e.g., power plant, industrial/research, radiological dispersal device, nuclear detonation)
  - Detection and dosimetry equipment for EMS/hospitals
  - Decontamination protocols
  - On-scene triage/screening, assembly center, and community reception center activities
  - Treatment protocols/information
  - Coordination mechanisms with hematology/oncology centers and RITN
- Chemical (FY 2023)
  - Determine risks for community chemical events (e.g., industrial, terrorist, transportation-related)
  - Decontamination assets and throughput (pre-hospital and hospital), including capacity for dry decontamination
  - Determine EMS and hospital PPE for HAZMAT events
  - Review and update CHEMPACK (and/or other chemical countermeasure) mobilization and distribution plan
  - Coordinate training for their members on the provision of wet and dry decontamination and screening to differentiate exposed from unexposed patients
  - Ensure involvement and coordination with regional HAZMAT resources (where available), including EMS, fire service, health care organizations, and public health agencies (for public messaging)
  - Develop plans for a community reception center with public health partners

ASPR has clarified the special surge annex tabletop/discussion exercise format and data sheet requirement for each required specialty surge annex (i.e., FY 2019 Pediatric Care Surge Annex, FY 2020 Burn Care Surge Annex or Infectious Disease Preparedness and Surge Annex, FY 2021 Burn Care Surge Annex or Infectious Disease Preparedness and Surge Annex, FY 2022 Radiation Emergency Surge Annex, and FY 2023 Chemical Emergency Surge Annex). Recipients and HCCs **must** validate their specialty surge annexes via a standardized tabletop/discussion exercise format that meets HSEEP principles for exercises and planning. The data sheet is a web-based form and is being developed as a module in the

CAT where the data can be input directly. Detailed instructions will be provided regarding the specific information that should be entered into the CAT.

NOTE: The Pediatric Surge TTX and associated data sheet in the CAT were waived in FY 2019 due to real-world COVID-19 response.

ASPR has clarified the requirement for incorporating transfer agreements into corresponding specialty surge annexes. Transfer agreements with pediatric, trauma, and burn centers should be referenced in the corresponding HCC specialty surge annexes. HCCs are not required to obtain a copy of all transfer agreements, nor do they need to be included in the annex; however, HCCs should be capable of demonstrating their knowledge of existing transfer agreements that support each specialty surge annex. HPP FPOs will verify the availability of transfer agreements during recipient site visits. ASPR understands that some specialty centers do not use written transfer agreements but will always accept referrals (subject to resources available). If this the case, a statement by the specialty center to this effect will suffice.