

**Hospital Preparedness Program (HPP) Healthcare Preparedness  
Capability Review National Call  
Capability 10: Medical Surge and Immediate Bed Availability (IBA)  
Meeting Summary  
Thursday, May 30, 2013**

**I. Welcome and Introduction to the HPP Healthcare Preparedness Capability 10 and IBA National Call**

— David Rykken, Scott Dugas, HPP

David Rykken and Scott Dugas welcome everyone to the HPP Medical Surge/IBA call to discuss HPP's innovative approach to implementing HPP Healthcare Preparedness Capability 10. HPP welcomes representatives from the Hospital Associations, State and territorial HPP directors, Hospitals/Healthcare Organizations (HCOs), Healthcare Coalition Executive Working Group (HCEWG) members, State/ territorial public health representatives, and CDC Public Health Emergency Preparedness (PHEP) colleagues to the call. The intent of this call is to share information about Capability 10: Medical Surge across a wide spectrum and to operationalize that capability by discussing IBA.

**II. HPP Performance Measure Update**

— Pamela “Shayne” Brannman, HSEB

Shayne Brannman is the Acting Chief of the Healthcare System Evaluation Branch (HSEB). In the past, Ms. Brannman has assisted the Assistant Secretary for Preparedness and Response (ASPR) in the development of state- and local-level work products and operationalizing the Medical Surge Capability and Capacity (MSCC) handbook. Her current efforts related to crisis standards of care, have allowed her to explore surge capacity in the context of a continuum of care, based on resource availability and demand for healthcare services.

The final HPP performance measures (PMs) will become effective on July 1, 2013. These revamped PMs emphasize the decisions, implementation strategies, and stewardship of resources that must occur along the continuum of care. An IBA discussion is very timely and relevant to the review process of the HPP PMs. The Healthcare Coalition (HCC) is the unit of measure to implement medical surge and IBA.

Under the medical surge capability, there are two data elements associated with IBA:

1. The HCC has tested its coordinated mechanism to both deliver appropriate levels of care to all patients and to provide no less than 20 percent immediate availability of staffed member beds within four hours of a declared disaster.
2. The HCC has demonstrated the ability to do the following during an incident, exercise, or event:
  - 1) monitor patient acuity and staff bed availability in real-time
  - 2) Off-load patients
  - 3) On-load patients.

### III. The NEW Medical Surge Model

- Dr. David Marcozzi, Healthcare Preparedness Programs Division
- Dr. Rick Hunt, ASPR Senior Medical Advisor

Dr. Marcozzi would like to thank the 62 Awardees for doing excellent work in their communities and becoming leaders in emergency preparedness. The Awardees have helped shape the HPP Capabilities and PMs and the Healthcare Preparedness Program as a whole. Today we will discuss an innovative approach to medical surge and IBA as outlined in the presentation, “A Thread of Preparedness within Healthcare.”

#### The History of the Hospital Preparedness Program (HPP)

HPP started in 2002, and was moved under the Office of the Assistant Secretary of Preparedness and Response (ASPR) in 2006. HPP helps healthcare organizations and communities to prepare and respond to public health and healthcare disasters.

- **The HPP Mission:** To improve healthcare preparedness and response by providing leadership, funding, evaluation, and technical assistance to HPP awardees.
- **The HPP Vision:** A robust, integrated federal, state, and local disaster healthcare system that coordinates all components of health delivery, supporting Emergency Support Function #8, to realize greater national healthcare preparedness, response, and recovery.
- **HPP Capabilities:** HPP’s capabilities are aligned with the PHEP capabilities. Dr. Marcozzi emphasized that preparedness programs are a leader in aligning healthcare delivery and public health. The HPP Capabilities are:
  - 1) Healthcare System Preparedness<sup>1</sup>
  - 2) Healthcare System Recovery
  - 3) Emergency Operations Coordination
  - 5) Fatality Management
  - 6) Information Sharing
  - 10) Medical Surge (Immediate Bed Availability)
  - 14) Responder Safety and Health
  - 15) Volunteer Management

#### Our Current Healthcare System Situation

Currently, today’s healthcare system is based on a “just in time” (JIT) supply chain and staffing model. This model presents a challenge when hospitals and healthcare systems attempt to build in medical surge capabilities. In fact, the U.S. as a nation may be less able to surge than in the past as evidenced by the declining number of beds available.

Year	Number of Beds per 10,000 People
<b>2000</b>	36
<b>2006</b>	33
<b>2012</b>	30

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<sup>1</sup> HPP conducted a Capability 1 National call on 5/6/13. A meeting summary is available upon request.

It is important to consider the following concepts when discussing IBA:

- The United States health care delivery system is focused on cost reduction which includes service retraction resulting in JIT operating principles and staffing.
- While United States health system emergency preparedness and response mechanisms are established and operational, they can be fragmented and are restrained by a JIT approach.
- The United States continues to experience overcrowding in emergency departments with limited mechanisms to reallocate patients throughout the hospital or the community.
- Our day-to-day system does not serve us well; therefore, it is not likely to serve us well on “game day.”

HPP believes that to advance the level of national preparedness, it is necessary to link emergency preparedness with routine care. The saying “If we can’t do it today – we can’t do it on game day,” is very applicable to emergency preparedness and response. HPP considers HCCs to be 100 percent prepared if they are functional and can exercise the eight capabilities during a real event.

### **Healthcare and Preparedness Financials**

- In 2009, National Health Expenditures grew 4% to \$2.5 trillion, or \$8,086 per person and accounted for 17.6% of Gross Domestic Product (GDP). The healthcare industry is built on a competitive market.
- In 2010, hospital expenditures were \$814 Billion. (CMS)
  - According to the American Hospital Association, there are 5,754 hospitals in the United States.
  - Average Hospital Expenditures are approximately \$141 million.
- The HPP 2012 budget is \$347 million, which is 0.0001% of overall National Health Expenditures.

These financial constraints are one reason why the HCC model is so critical. It is essential that various community healthcare organizations (HCOs) work in partnership to achieve a better prepared community. Leveraging resources and linking to daily delivery of care to create a scalable, coordinated system based on the ESF-8 construct is essential.

### **Our Current Need – HCCs**

- A comprehensive national preparedness and response health care system that is scalable and coordinated to meet local, State and National needs
- A dual use application to preparedness, integrating with and improving the efficiencies of daily health delivery
- A financially sustainable approach to preparedness
- A population-based health delivery model for disaster response
- Defined Healthcare Preparedness Capabilities and Performance Measures

Even though hospitals and healthcare systems are competitors in the Health industry, they must work together during disasters to increase the survivability of victims. The HCC model is built on the premise that the “whole is greater than the sum of its parts” and robust HCCs are essential to emergency response. HCCs are the cornerstone of the current HPP and ASPR strategy moving forward. Robust HCCs are essential to emergency preparedness and response. HCCs need to be linked with the daily delivery of care to perform the eight capabilities.

For a HCC to be successful, the right partners need to be at the table (e.g., Hospitals/HCOs, Primary Care Providers, Emergency Managers, Emergency Medical Services (EMS), and public health). In addition, insurers participate in HCC discussions to provide their expertise. Examples of entities involved in a HCC are: alternative care sites (ACSs), behavioral health providers, community-based organizations, community health centers, dialysis facilities, emergency management, faith-based organizations, hospitals, long term care facilities (LTCFs), National Disaster Medical System (NDMS), primary care providers, public health, private insurance, urgent care facilities, volunteers. First, you need to have the right team (HCC), and HCCs implement and exercise the capabilities. The performance measures are the targets (touchdowns) the team strives to achieve.

HPP looks forward to working with its partners to build HCCs, execute the HPP capabilities, and implement and achieve PMs, especially those related to IBA.

It is essential that HCCs across the nation:

- 1) Link with daily delivery of care
- 2) Achieve a complete and robust functionality and the ability to execute the capabilities
- 3) Consider *risk* and adjust activities accordingly. *Risk* is defined as: those areas of higher threat and areas of more vulnerable populations
- 4) Increase percent of population that HCCs cover. With resource constraints and a \$350 million HPP budget, this is an important area to consider and address.

### **New Medical Surge Model**

- Goal: To quickly provide higher-level care to more serious patients during a disaster with no new space, personnel, or equipment
- HPP 2012 Medical Surge Capability PM: Ability (of HCCs) to provide no less than 20% bed availability of staffed members' beds, within 4 hours of a disaster

### **Former Model vs. New Model of Medical Surge**

The former construct of medical surge considers building medical surge and extra beds in addition to the current hospital/healthcare facility capacity. In the current economic climate, this model will most likely not be successful. The new construct builds in surge within the current system, making medical surge more sustainable. For example, 20% IBA can be achieved with current hospital departments or facilities across the HCC. Those patients with lower acuity can be transferred to other departments, transported to HCC members (e.g., LTCFs, community health centers), or discharged home.

The U.S. needs strong HCCs to address medical surge challenges. There have been valid concerns regarding the ability of healthcare organizations to achieve medical surge, and HPP has worked on a new approach to IBA. IBA does not deal with beds alone. Essentially, it requires hospitals/HCOs to care for acutely ill victims of disasters with no new personnel, space, etc.

### **IBA is:**

1. Evidence-informed
2. Operationally Tenable
3. Economically Sustainable
4. Ethically Grounded

1. **Evidence-informed:** A study on “Reverse Triage” has been conducted. In Reverse Triage, inpatients at low risk for untoward events would be discharged or transferred back to the community.

Reverse Triage Study Summary:<sup>2</sup>

- Three hospitals, 19 week monitoring, 1,632 total beds
- Hospitals achieved a net surge capacity of 66-81% after accounting for non-disaster emergencies
- Majority of surge would have been available 24-48 hours after disaster

## 2. Operationally Tenable

### **Operationally Tenable: Space<sup>3</sup>**

Every day, approximately 20% of hospital patients are discharged. However, every day, even more patients *may* be available for discharge. For example, clinically stable patients with few parenteral medications may be appropriate for early discharge. Strategies to expedite discharge include strategies that hospitals currently use to reduce overcrowding.

Some examples are:

- Discharge holding lounge
- Convert private rooms to double rooms
- Reopen closed areas
- Utilize hallways
- Convert patient areas to critical care areas
- Temporary external structures for patient holding
- “Flat space” (e.g. lobbies, waiting rooms, hallways) can open 10% operating bed capacity

### **Operationally Tenable: Staff<sup>4</sup>**

Staffing is likely to be the key restriction on the number of patients that facilities and coalitions can accommodate. HCCs should consider:

- Protocols for revision of staff work hours
- Callback of off-duty personnel
- Use of non-clinical staff
- Local Medical Reserve Corps
- Untraditional patient care providers (e.g. family members, nonprofessional personnel such as city employees)
- Surge plans for home care agencies and clinics
- Fewer, larger staffed off-site facilities will benefit from economies of scale

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<sup>2</sup> Kelen, “Creation of Surge Capacity by Early Discharge of Hospitalized Patients at Low Risk for Untoward Events, Disaster Medicine and Public Health Preparedness, 2009.

<sup>3</sup> Hick, Hanfling, et al., “Health Care Facility and Community Strategies for Patient Care Surge Capacity,” Annals of Emergency Medicine, 2004.

<sup>4</sup> Hick, Hanfling, et al., “Health Care Facility and Community Strategies for Patient Care Surge Capacity,” Annals of Emergency Medicine, 2004.

### 3. Economically sustainable<sup>5</sup>

- Building disaster preparedness into existing healthcare systems makes the process economically sustainable, and allows for surge capacity without extra “staff, space, or stuff.”
- Private partners and insurance companies need to be involved. Billing will be an issue but can be mitigated through stakeholder buy-in.

### 4. Ethically grounded<sup>6</sup>

During overwhelming disasters, decisions must be made as to who can best be served. Medical ethics are grounded in: autonomy, beneficence, non-maleficence, and justice.

Consent to “be triaged” is implicit in consent to give medical care:

- Applied in routine clinical care, military operations, public health, or population level emergencies
- Utilitarian versus egalitarian, proportionality of care
- Victims of disaster treated equally to existing patients

### The three pillars of IBA are continuous monitoring, off-loading, and on-loading

1. **Continuous Monitoring:** Continuous monitoring is essential, because “in a moment’s notice,” responders need to know where the 20% of available staffed beds are. Elements important to continuous monitoring include:

- Maintain operations
- Monitor patient acuity in real-time
- Continually establish disaster disposition protocols
- Greater than half of HCCs use electronic data and information sharing systems and have tested communication systems protocols internally and with relevant stakeholders
- Communication between coalitions is less prevalent
- Examples of Continuous Monitoring systems: WebEOC, Health Alert Networks (HAN), and bed tracking systems

2. **Off-loading:** This act of discharging low-risk patients to other HCC entities or to their home has a huge economic impact on the facility. Components of off-loading include:

- Disaster disposition protocols utilized
- Rapid bed turnover
- Discharge or Transfer of lower acuity patients to coalition partners/home
- Deferral of elective admissions/procedures, etc.

### Real World Examples of off-loading:

Real World Example 1: Ashmore Reef Explosion, 2009:<sup>7</sup> Reverse Triage in Practice (Royal Darwin Hospital, Australia)

- Event: Boat explosion injured 30 asylum seekers
- Royal Darwin Hospital was full with emergency department backlog

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<sup>5</sup> Medical Surge Capacity Workshop Summary, 2010, [http://www.nap.edu/openbook.php?record\\_id=12798&page=135](http://www.nap.edu/openbook.php?record_id=12798&page=135)

<sup>6</sup> Kraus, Levy, et. Al, “Lifeboat Ethics: Considerations in the Discharge of Inpatients for the Creation of Hospital Surge Capacity,” *Disaster Medicine and Public Health Preparedness*, 2007.

<sup>7</sup> Atkinson, Satterwaite, “Using reverse triage to create hospital surge capacity: Royal Darwin Hospital’s response to the Ashmore Reef disaster,” *Journal of Emergency Medicine*, 2012.

- Disaster Response Team activated reverse triage
- Elective procedures cancelled, multidisciplinary teams assessed patients, increased use of community care (nursing facilities), discharged patients
- In 4 hours, 56 beds were available (16% of capacity)
- Only one patient returned for further treatment

#### Real World Example 2: Hurricane Sandy, 2012<sup>8</sup>

- “Where possible, investments should be coordinated across multiple institutions, using health care coalitions to ensure resiliency”
- Improved Situational awareness
- Drilled evacuation (IBA off-load)
- “Measured success” in Sandy with transport
- Improved clarity of criteria and triggers for evacuation

#### Real World Example 3: Seasonal Influenza, 2013.<sup>9</sup> Strategies used during January 2013 seasonal influenza include:

- Expedited patient case management (discharge planning techniques)
- Decompressed inpatient wards
- Isolated hospitals cancelled elective admissions and procedures

#### Real World Example 4: Rashid Hospital, Dubai<sup>10</sup>

- **Disaster response challenges:** Lack of bed space, congested operating rooms (ORs), uncoordinated medical management
- **Root Cause Analysis:** Physicians continuing with “normal business” (e.g. ward rounds, patient assessments) in spite of disaster status, no system or recognition for need for reverse triage, ORs continue with routine cases with lack of leadership in this area
- **Improvement strategies:**
  - Reverse triage education
  - Transfer to other facilities if specialist interventions not required within 24 hours
  - Increasing bed capacity and routinely clearing patients
  - Hospitalists
  - Extended discharge lounge facilities
  - Liaison with construction companies regarding expatriate patients’ “transport home”
  - Liaison with local police to allow access
  - Medical Staff have “mini-card” with reverse triage guidelines to use during emergencies

### 3. On-load: Redeploy existing resources to allow for higher-acuity admissions

- On-loading takes place in emergency departments every day and will continue to take place regardless of challenges of space, staff, stuff
- The continuous monitoring and off-loading of IBA allows on-loading to take place in an efficient manner that does not compromise patient care

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<sup>8</sup> JAMA, 2012.

<sup>9</sup> Health System Stress Assessment, OPEO, 2013.

<sup>10</sup> Griffiths, et. al, “A framework for physician activity during disasters and surge events,” Disaster Medicine Journal, 2011.

**Real World Example, On-loading:** Madrid Terrorist Bombing, 2004<sup>11</sup>

- On March 11, 2004, 10 terrorist explosions occurred almost simultaneously on commuter trains in Madrid killing 177 people instantly and injuring more than 2,000
- That day, 966 patients were taken to 15 public community hospitals. More than 270 patients arrived at the **closest** facility between 8:00 AM and 10:30 AM (2.5 hours)

**International On-loading Lessons Learned:** There have been many lessons learned from Madrid and other disasters (e.g., explosions in London, Mumbai, Karachi, Delhi, etc):

1. Injured and dead will arrive at closest hospital
2. Closest hospital is unable to meet the demand, and thus will experience a functional “collapse”
3. This leads to a compelling need to distribute patients to other hospitals and entities within a region or HCC

**IBA and Pandemic**

IBA attempts to push healthcare systems toward the left hand side of the conventional – contingency – crisis standards of care continuum. Continuous monitoring will be needed across the system during a Pandemic, so it’s very useful to review IBA in the context of a Pandemic. Off-loading will be needed to make space for sicker patients and on-loading will be needed since sicker patients will need acute care resources.

Pandemic care may reach a tipping point where crisis standards apply, requiring:

- More staff: locum tenens/traveling nurses
- More stuff: medical countermeasures
- More space: use of planned and unplanned alternate care space (e.g., hotels)
- Fatality management

Meeting the 4 hour IBA requirement is a foundation for building surge capacity for events that have much longer time spans. Meeting the 20% staffed bed requirement will help, but may or may not be enough to accommodate sustained volume increases.

**IBA examples in recent experiences:**

- After the Boston Bombings, healthcare Systems in Boston did an extraordinary job of distributing patients among various hospitals. For example, one hospital off-loaded 30 patients from their emergency department in 20 minutes. These patients were either discharged home or transferred to other floors for additional care.
- In a recent explosion event, HPP received a report that hospitals immediately implemented surge plans. Hospitals quickly moved lower acuity patients to other healthcare facilities and organized more bed space. Local surgeons were notified that elective surgeries may be canceled due to increased demand from the incident. Hospital staff reported that they were prepared for 20% surge, and during the response, they discovered they could have surged beyond 20%, if necessary.
- HPP saw a report regarding continuous monitoring of bed availability after a recent tornado incident. Bed availability was tracked for red, yellow, and green patient categories.

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<sup>11</sup> CDC. (2010). In a Moment’s Notice: Surge Capacity for Terrorist Bombings. (pgs 2-4).



### **Further IBA Considerations:**

There is need for progress in this area and HPP recognizes inherent challenges in achieving IBA (e.g., specific challenges in rural areas). Some additional areas for further discussion include:

- Federal Regulations
- Jurisdictional Considerations
  - Triggers/Thresholds (e.g., when do you activate IBA)
  - Transportation
  - Liability
  - Staff/public education
  - Rural issues

Even though there are Medical Surge challenges, this new IBA model is tenable and practical, and HPP has seen some positive outcomes from this model. Dr. Marcozzi emphasized that it is important to weave preparedness into the routine delivery of care starting today. It is HPP's vision that an entire nation's healthcare system can understand, appreciate, and implement IBA.

The U.S. changed an entire system of care with one quality measure: door-to-balloon time. This measure codified, mandated, and formalized the relationships between EMS, the Emergency Care System (e.g., emergency physicians, EDs), cardiology, and hospital executives so that healthcare providers in the U.S. can care for victims suffering a heart attack within 90 minutes. It is a national standard and, when it started, it was considered too difficult to achieve. Now it is the measure that the U.S. stands on to deliver acute coronary care. The concept of IBA mimics a time-bound standard to provide a quantifiable metric that allows for better and greater availability of our nation's delivery system to provide care during disasters.

### **IV. Questions and Answers**

— Group

- **Question:** I am pleased to see the development of the HCC concept. There are major issues with coordinating pre-hospital and hospital care and it is important to make progress in this area. As demonstrated in real-world events and documented by literature, most patients end up at the closest hospital after a disaster. This may be because many patients are transported by private vehicles or citizens performing search and rescue activities. One strategy to address this is to designate the closest hospital as a triage and stabilization center. Patients are then referred and transferred to other hospitals in areas which have not received as many patients from the incident. A challenge to this concept is the Emergency Medical and Treatment and Labor Act (EMTALA). Has there been any progress in making a "disaster exemption" for the EMTALA regulation for communities that have developed a holistic community plan for patient distribution during disasters?
  - **Answer:** ASPR is engaging with CMS partners to explain how HCCs are being implemented and executed, including the concept of IBA. ASPR and CMS also continue to discuss appropriate use of 1135 waivers in a disaster. 1135 waivers must be reviewed in the context of the ability to distribute patients in the aftermath of a disaster. ASPR welcomes CDC collaboration in this area.
- **Question:** I have been working on a research proposal related to the issue of patients with on-going and chronic diseases losing access to their routine sources of healthcare. This may result from infrastructure damage to non-hospital healthcare facilities including pharmacies, dialysis

centers, community clinics, etc. Conducting reverse triage activities may worsen this phenomenon, especially if a disaster causes damage to non-hospital medical assets. Are any efforts underway to identify how often disasters cause limited access to non-hospital assets and what interventions are in place to mitigate this (e.g., zoning requirements or building codes for healthcare facilities)?

- **Answer:** When infrastructure is damaged, it impairs a facility's ability to function. Healthcare facility continuity of operations (COOP) is a very important concept, which HPP emphasizes. HPP's intent is to promote a coalition-based approach: If HCCs can better support each other, they can also support their communities (e.g., transfer patients from an affected facility to an operational facility), and share resources appropriately to mitigate issues such as patients losing access to care.
- **Question:** Is there a map of current HPP HCCs? This exercise would facilitate identifying areas where there are gaps in HCC coverage that need more development.
  - **Answer:** HPP is currently mapping HCC development with various cross-sections including Accountable Care Organizations (ACOs), EMS, trauma systems, and rural partners (e.g., Critical Access Hospitals (CAHs)). This will allow HPP to explore how these entities align. HPP will provide these tools to the ESF-8 leads within each jurisdiction to assist in HCC planning. In addition, it is important to consider the concepts of percent population served, risk, functionality, and healthcare delivery when conducting HCC planning activities.
- **Question:** HCCs are the key to the entire IBA process. However, hospitals are very competitive organizations that try to perform better than the other hospitals in their geographic region. There must be incentives that force these hospitals to work together, as these facilities believe that information regarding bed and staff availability is proprietary. There have been cases during emergencies that hospitals have not shared staff or resources with other facilities in need. How do we change the mind-set of hospital leadership to cooperate with each other?
  - **Answer:** There are various solutions to this issue, and it is important to approach these challenges in different ways. First, there needs to be financial incentives. Federal funds may provide some incentive, however, "you can't grant your way to success." Linking up to daily delivery of care systems, including how healthcare regulations are instituted is essential. This would facilitate a shared community interest and shared expectation of working together during an emergency among various healthcare partners, whether they are private, academic, long term care etc. The first step is deciding on which regulations and incentives would facilitate healthcare systems working together. Second, there are financial benefits of participating in a HCC. HPP would like to drive discussions on this topic in the future.
- **Question:** The equipment that got our hospital up to emergency preparedness standards has not been maintained or updated in the last six years. Are equipment purchases, updates, and maintenance still a viable way to spend HPP funds?
  - **Answer:** The program focus has shifted from purchasing "stuff" to developing capabilities. In the past, Awardees purchased items and some of the purchases were not appropriate or necessary. The program evolved with more emphasis on building infrastructure, and providing training, etc. HPP supports equipment purchases if they are appropriately planned, support infrastructure that is linked to HPP capabilities, aligned with operational plans, and meet a need that has been demonstrated through exercises.

- **Question:** New Mexico is a rural state with two metro areas. Regarding the medical surge data element of achieving 20% IBA in four hours, is it possible to implement this capability across different coalitions (not just within one HCC)?
  - **Answer:** The intent of the Performance Measure (PMs) is to achieve 20% IBA within one HCC, regardless of the size of the HCC. HPP understands the inherent challenges of achieving IBA in rural areas and is exploring the concept of “cross-coalitions.” It is necessary for HPP to be very precise and specific on the PM, but HPP would like to be supportive of jurisdictions with innovative approaches to make IBA meaningful and achievable to increase survivability during disasters. There will be disasters that necessitate multiple HCCs to collaborate to meet a community’s need. An important goal is to formalize and institutionalize HCCs so they are able to work with each other, which will contribute to building a local, state, and national asset that can be activated during disasters.
  
- **Question:** Do any hospitals use standardized discharge orders and instructions to off-load patients to HCC partners during an emergency?
  - **Answer:** Dr. Hunt is not aware of any standardized discharge orders currently being utilized. There are models and templates for discharge orders that can be potentially used during a disaster that should be part of an IBA toolkit. A tool such as the mini-card with reverse triage guidelines utilized in the Rashid Hospital in Dubai is an example tool to consider when implementing IBA.
  
- **Question:** Is there any discussion about making the IBA data element a patient safety goal?
  - **Answer:** It is very important to explore how IBA links with patient safety. Achieving 20% IBA in disasters is important to provide quality care to victims of a disaster. HPP will consider this issue as they explore future opportunities for engagement.
  
- **Question:** What are possible strategies to document and test HCC ability to meet the 20% IBA requirement within 4 hours and provide patient care to both inpatients and those patients that were off-loaded and on-loaded? What documentation is required to assure HPP that HCCs have met these standards?
  - **Answer:** During an event, continuous monitoring plays a significant role when implementing IBA. Healthcare facilities do not automatically off-load 20% of their patients when an event occurs. Facilities wait for patients to come in, the situation is monitored, and healthcare facilities act accordingly. There should not be any major changes in documentation, as the healthcare facility is still providing care, but in this case, staff is treating disaster victims. Documentation strategies include tagging and tracking disaster patients, and tracking methods of making beds available (e.g., early discharge or patient transfer) across the HCC.
  
- **Question:** Please address how this IBA model interfaces with nursing homes, which have a significant role in offloading hospitals and yet are not able to manage many day-to-day roles effectively.
  - **Answer:** A recent Office of the Inspector General (OIG) report recommended that LTCFs need to participate in emergency planning efforts to ensure continuity of operations. HPP is moving from the traditional hospital-focused system to a HCC

approach, which includes a variety of partners, including LTCFs. HPP is currently examining how HCC partners engage LTCFs.

- **Question:** I agree that developing robust HCCs is an appropriate approach to making preparedness efforts more sustainable. The phrase, “we can’t grant our way to preparedness” captures the important financial implications of being engaged with HCCs. Does HPP or ASPR have a marketing toolkit that Awardees can utilize when engaging with possible HCC partners? Our state is beginning to have discussions with HCC members about sustainment strategies beyond ASPR funds.
  - **Answer:** There are many different reasons to participate in and engage with HCCs, and there are various models of HCCs that have been successful. For example, there are HCCs in Florida, Washington, and Indiana that would be sustainable without ASPR funds. It is essential that HCC leaders consider sustainability issues, such as linking with the daily delivery of care, during planning activities, especially in the current economic environment. For example, it is important to consider how preparedness links with healthcare system activities (e.g., operating procedures, billing procedures, information technology/electronic health records, legal issues, etc.). Each jurisdiction has its own set of challenges and HPP would like to work with ESF-8 leads to support various HCC models and sustainability strategies.
  
- **Question:** Will participants have access to the presentation that was used during today’s call?
  - **Answer:** HPP will not distribute the PowerPoint slides that were used in today’s presentation. However, HPP will provide a meeting summary and a link to the web meeting replay. Awardees will be able to access this link for six months.

## V. Concluding Remarks

HPP would like to thank the HCEWG members, HPP Awardees, CDC PHEP colleagues, and other healthcare and public health associations for supporting HPP and participating in today’s call. HPP encourages Awardees to plan for the HCC meeting in New Orleans, Louisiana in December 2013. HPP encourages Awardees to participate in the following upcoming National Capability and Special Topic Calls:

- June 20, 1:00 PM ET: Pediatrics/Pediatric Emergency Care
- July 1, 2013 – 11:00 AM ET: Capability 3: Emergency Operations Coordination
- August 12, 2013 – 11:00 AM ET: Capability 6: Information Sharing
- September 14, 2013 – 11:00 AM ET: Capability 14: Responder Safety and Health