

ASPR Hospital Preparedness Program Health Care Coalition Webinar

October 10, 2024

Call Transcript

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Olugbadero Yerokun: We can move to the next slide. Thank you. I'll start by going over the meeting agenda first. We'll provide an overview of the Fiscal Year 2024-2028 HPP period of performance outcomes, and the MRSE requirements for HCCs and recipients. Then we'll provide a summary of the MRSE updates, in addition to how the MRSE's flexibility can help you meet the requirements of other exercises. Finally, we'll leave time at the end to answer all of your questions. Next slide, please.

And now I'll pass it over to Dave Cernak and Captain Sheehan to present our MRSE updates. Over to you, Dave.

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David Cernak: Good morning, everyone, and welcome to our call today. Thank you for taking some time out of your busy days right now. I know there's a lot going on across the country. So I just wanted to say, thank you for taking a few moments out of your day to join us on this call. We look forward to kicking off some new discussions today, hearing some good questions, and then kind of setting us up hopefully for next week's office hours, where we'll be able to dive a little bit deeper into some of your specific questions, example scenarios, and maybe do a little bit of brainstorming and come up with some great ideas to help everyone here be as successful as possible with this year's MRSE as well as with future MRSE exercises as we move forward. So with that said, let's kick over to the next slide here, and let's start at a high level, and ask ourselves, and just kind of review why we're the MRSE, right?

So, as many of you know, we started the MRSE several years ago, and it has been evolving, each year based on a lot of the feedback and a lot of the information that health care coalition members have provided back to us. You all have been great at troubleshooting issues, coming up with new ideas and new solutions, and looking for ways to make the MRSE a much more valuable component of your health care coalition, and as a much more valuable tool for evaluating and strengthening your current capabilities and core functions.

As we moved into this new period of performance, we updated the MRSE a little bit. Not a lot. It's just minor refinements based again on a lot of your feedback and some of the updates in the new NOFO from a high level. Why are we doing the MRSE? And why are we continuing to do MRSE? Three big overarching reasons. The first one is to help you address the needs of your community, your jurisdiction, your partners, your members, and your health care organizations. We want to make sure that you have a tool and a resource available to help you meet the needs of those organizations in your jurisdiction.

We also are doing it to help build connectivity, strengthen those partnerships, strengthen those bonds, the coordination, the collaboration at the local level, the facility level, but also at the state and the regional level. We want to make stronger connections, stronger partnerships. So this way, when time comes and we have to respond to that next emergency or disaster, we have those partnerships, we have those plans, we know each other, and we can work together more efficiently to respond to that emergency or disaster. And lastly, and most importantly, it's really to save lives. The MRSE enables you to review those plans, evaluate those plans, conduct,

training, look for ways to improve the actions that you take, the resources that you have in order to more effectively save lives during emergencies and disasters. So that's kind of the big picture as to why we're doing the MRSE and how the MRSE can add value to your organizations.

But when we look also at what the outcomes are for this next 5 year period of performance, the MRSE really does tie into each one of those outcomes as well. When we talk about establishing multi-year priorities, the MRSE is an opportunity to take those priorities, to focus in on them, to look at the plans, look at the resources, look at our structures and our organizations, and then conduct training and exercise to help meet those priorities and those needs both at the state and strategic level, but also at your coalition level and at the facility level.

It's really here to, like I said, help enhance and sustain your organization as a health care coalition. It allows you to bring in new members, strengthen existing memberships, refine your plans, refine the resources that you currently manage and have access to, and make sure that your organization has the ability to rapidly mobilize and support emergency or disaster when it does occur.

When it comes to coordination, the MRSE is a great opportunity to exercise those connection points right? Not just within your organization, but also with local emergency management. Local public health integrate fully into the Esf-8 structure in your community, and then hopefully as well be able to communicate up to the Esf-8 structure at your state level. It allows you the opportunity to take the roles and responsibilities assigned to your coalition during an emergency response and exercise. Just make sure that they're appropriate and make sure that you can perform them, and, if need be, look for new ways and additional ways to be able to support and respond during the next emergency.

And then, lastly, like we talked about that saving lives component maintaining that continuity of healthcare service delivery, right? Making sure your plans are appropriate and functional, that if there's things that you need to update from year to year, or you need to modify in order to improve that ability to maintain service delivery, maintain function, and support those members within your coalition during an emergency disaster, that your plans, your resources, your structures, all can do that to this way allow healthcare providers and public health providers to continue to provide service to individuals during that response and maintain that continuity healthcare during a disaster, and then into moving into recovery. So with that said, Let's jump to the next slide.

When we look at the MRSE, we know each year the basic requirement has been to conduct the MRSE, evaluate the MRSE, and look for ways to improve from year to year, right? There are three standing requirements in addition to the overarching requirements that are in the NOFO. Those overarching requirements being this year based on a lot of feedback that was provided by coalitions.

We standardized the way forward with utilization of HSEEP, in order to help improve that connectivity, improve that coordination between other partners, members, and organizations, and within your coalition itself. Standardizing the use of HSEEP practices throughout the exercise is one way that we're trying to help folks move forward and support you. Another one is looking for ways to incorporate those communities most impacted by disasters, those at risk populations. That's another component that we want to look to have incorporated into all activities and exercises across the board, looking for those populations within your health care coalition that may be at the greatest risk, or have the greatest or unique needs. Making sure that

there's some aspect in one of your exercises that helps to address that, to make sure that your plans appropriately account for those individuals, so that way we're making sure that during a disaster that we have the right processes, the right plans, the right resources in place to help meet those special needs, whether it's cultural, whether it's an age group or demographic, whether it's a geographic component of your health care coalition, whatever those at risk populations are, that there's some component of your exercise that helps to address them as well.

Overall, when it comes to the MRSE, we want you guys to plan, execute, and evaluate effectively each year an exercise that really aligns with the hazards and risks of your jurisdiction, that helps meet your greatest needs and priorities, and focuses on those areas that you want to focus on that year to help strengthen very specific core functions or capabilities within your organization or within your state, depending on what the exercise is, giving you that opportunity to validate those plans. We also want you to look and focus on building new partnerships and strengthening existing partnerships. By doing this, you will have a much stronger organization. Your ability to function during an emergency and disaster will be much more effective, and you'll be able to provide that care and services needed by practicing, rehearsing, exercising, and validating what you currently have in place in, in a controlled exercise environment.

Lastly, making sure that we do a good job documenting the actions, documenting our activities to evaluate them, looking for areas of improvement, identifying those corrective actions, and bringing it all together. So this way, you're setting yourself up for the following year to be able to start addressing those corrective actions, and then again incorporating those changes into the next year's exercise, and moving forward. So thinking about the MRSE as an ongoing continuous cycle.

If you do these items, just these few things - plan, execute, strengthen partnerships, document whatever happens, whether it's good or bad in your exercise - you really will be successful and we hope that as you continue to do this, your coalitions will continue to grow and improve and be strengthened year after year. Next slide, please.

We want to make sure you guys are also tracking the fact that we've heard that there is sometimes a disconnect and a need for additional support outside your coalitions. Not every coalition is equal, right? Every coalition is very unique. Some coalitions have great strengths, and then some coalitions are very aware of some areas that they need to continue to work on developing. So, what we made sure we did this year as well, is identify some very specific requirements that every recipient at the state level is also required to conduct and perform, to help support you as a health care coalition, while you plan, execute, and evaluate your MRSE.

These are the five core things that we're asking every recipient to do. The first one being that they provide any additional, necessary support that you need throughout the exercise process. If you're struggling with building an exercise, or if it's new to you, you can lean on the recipient, lean on the state and ask them for assistance with the planning and the execution piece. If there are capabilities or resources that you don't have access to at the coalition level because they're maintained at the state level, that's the type of support that we want, the help that recipients will be able to provide you. So, this way you can effectively validate your plans. You can actually run it through your plans with the right resources and players at the table just like you would during a real emergency. We don't want you to try and fairy dust things as you move forward. We want

to make sure that the recipient is there to help provide you any appropriate support needed throughout the process.

The next is, we want to make sure that the recipients are helping provide the number of surge patients. We heard many times, from many coalitions in the past, that they spent sometimes an excessive amount of time trying to determine what that surge number should actually be for the MRSE. When it comes to the numbers, we want you guys to focus on the planning, the organizing, the equipping, the training, and the evaluating.

Coming up with a surge number shouldn't be the greatest burden of the entire exercise process. So what we're asking the recipients to do, is we want the recipients to provide that number to you. We're asking them to look at what the current licensed bed numbers are for the state, calculate that surge number appropriately by taking 10 percent of that, and provide that number to you. So this way, you've got your search target ahead of time, and you don't have to spend all your time trying to determine that number. We want the recipient to be able to provide it for you.

The next is that we want to make sure that the recipients are involved in the exercise scenario component, making sure that it aligns not just with your jurisdiction, but it also it falls in line with the state's high-level kind of strategic priorities and requirements of hazards and threats. We want to make sure that the scenario is appropriate. If there's an opportunity to bring in more partners from maybe outside your coalition, based on that scenario, that the recipient is at the table, and can provide that additional assistance, or build those additional connection points to assist you and help create a stronger, more meaningful, and valuable exercise.

Verification of any of the questions as far as specific roles and participation, the recipient needs to clearly communicate to the health care coalitions what their expectations are during a response of that coalition. What roles you may have, what responsibilities that they may expect you to perform during a response, we want to make sure that's clearly communicated. So, if there's any question or any doubts that you have on what your coalition should be doing to support that response, the recipient should be there to help provide that clarification and communicate exactly what they expect of you. This is so you can focus in and make sure that you're performing that role of meeting those expectations.

Lastly, from a quality assurance standpoint, sitting down reviewing the data that you collected , reviewing the information, reviewing your exercise, reporting tool, and working with you guys to make sure that the tool is not just complete, but the information is as accurate as possible, and that everything is together and looks good, and it's accurate. If there's any additional details that they want to incorporate or ask you to incorporate. But you all work together to make sure that the product is as complete as possible, and as polished as possible before you turn in the reporting information.

Considering there that there are several recipient level performance measures tied back to the MRSE, making sure that the recipient is assisting with the reporting component and the completion of that exercise reporting tool. So with that said, hopefully, that kind of gives you an overview of why we're doing it and how it ties into the outcomes. And then, looking at these requirements and how they all work together to make sure that you guys are as successful as possible when conducting the MRSE.

I know there's a lot of questions that are popping up in the chat. We will get to a lot of the questions towards the towards the end of the Q&A. So keep throwing them in there, and if we

don't get to them at the end of the Q&A, we'll make sure that we answer every one of the questions, and we have them provide the list back to you with all those answers after the webinar. So with that, I'm going to turn it over to Kevin to get into the specific updates of the MRSE itself.

Kevin.

00:15:03.460 --> 00:25:55.210

Kevin Sheehan: Thanks, Dave, and good morning, and to everyone, and good afternoon to our folks on the East coast, I know that we've got a lot of our partners, especially now, Florida responding and the southeast. Hopefully, they're doing well, they're safe there. I know they're going to be very busy over the next few weeks, and don't worry, we've got this presentation recorded, but we'll also be available to those coalitions in the southeast, and who weren't able to make this, and we'll walk through that with them. So let's proceed.

If you were on yesterday, yesterday's presentation was directed primarily to recipients and today it's directed toward health care coalitions. And so, if you were on yesterday, you're going to hear a lot of the same information. But hopefully, we'll have a little bit more feedback in the Q&A section with our coalitions.

So, our process for updating the MRSE, the main goal of updating the MRSE for this next 5 year period of performance, where it's to streamline data and to reduce burden on health care coalitions. The MRSE support team obtained feedback many, several, different ways, primarily direct feedback from many people on this webinar. We did go to the National HCC Conference and have presented there, and given folks opportunities to weigh in and talk about the pros and cons, and ways we would improve the MRSE moving forward. We've had meetings, we have office hours, numerous office hours, and we do have office hours next week.

We've had meetings with contractors who've actually worked with coalitions and done it, and had a lot of really good feedback for us. So those were kind of the primary ways that we've got information and took all that into consideration. Updating the MRSE. The MRSE support team also developed additional guidance and instructions based on requirements for the period of performance. So next slide, please.

We've now made some, as Dave mentioned, we've made some updates, not huge renovations of any of these tools. Just some updates to the Exercise Guide, the Evaluation Plan and the reporting tool. And I'm going to go over each of those in a little bit more detail, but on the Exercise Guide, which was previously known as the Sitman or Situation Manual, includes the recipient and HCC-level of requirements that we went over a little bit earlier.

The surge targets requirement has been reduced, and I know there's some folks who are just hearing about this. We did brief this out in July at a national webinar. So from 20percent of staff beds which were defined by 5 different bed types, as you remember, from the MRSE the last couple of years, to 10 percent of your licensed general medical surgical beds. We also updated language throughout the Exercise Guide to match the terminology used in the new NOFO.

The Exercise Guide can be found a couple of different ways. The Exercise Guide can be found in CAAMP and it will be available on the MRSE web page. But it's not available today because we have some backlogs with our Comms team and have asked for them to get things up on our web page. But you should have these tools, and if you don't have the tools, we'll definitely send

them out to you. Send a note to either your FPO or to the MRSE@hhs.gov inbox, and we'll forward these tools to you.

The next one we updated was the Evaluation Plan. It now includes our 9 performance measures tied to the MRSE, per requirements for the period of performance. Specifically, we updated language based on draft changes to the HPP performance measures. We've incorporated performance measure 12, the redundant communication to performance measures in the MRSE tool. We used to report on redundant communications through the CAT tool, the coalition assessment tool. We are no longer going to be using the coalition assessment tool or the CAT for this next period of performance. So you will be reporting about using redundant comms within your exercise in the MRSE tool. Again, the Evaluation Plan will be located on CAAMP as well as the MRSE web page when it gets up there.

The reporting tool, the Microsoft Excel spreadsheet that all of you have had to fill out, previously known as the Exercise Planning and Evaluation tool is now only called the reporting tool. It's been streamlined to reduce the burden of data reporting.

The exercise objectives have been reduced from 6 to 4. Our objectives still are, you know, participation where we have a couple of performance measures. With regard to participation, we have three performance measures tied to notification and information sharing. We have another three performance measures linked to assessing resources throughout your exercise. And then we have one on patient movement during a medical surge event in your jurisdiction. So that's how we have gone from 6 to 4 objectives.

The reporting tool will only be located in CAAMP, or we will provide you the reporting tool directly from us or from the recipients. They should all they have all these tools, and hopefully they can push them down to if you did not get them yourself.

Finally, the Real-World Reporting and Evaluation tool has been discontinued, and the reason we did that is because we found that the way that we made revisions to this new reporting tool, this updated reporting tool with some guidance that we've also provided, you can just go into the reporting tool and let us know that it was a real world event, and then you can report on that. But there are some we want to make sure that during a real world event you do have to seek out and discuss this with your recipient and your HPP Field Project Officer, so that we all can be in agreement that this really is an event that warrants stress on a medical response to the coalition. So that's something we want to make sure we have in place before we give you approval for using this reporting tool for a real world event. Next slide, please.

We've heard what you said, and what coalitions have said. They've had a lot of difficulty surrounding the initial surge target. We've had a couple of surge targets. One was 20 percent of staffed beds when we had something called the Coalition Surge Test (CST). That's no longer in place. We've looked at the 5 bed types from the previous MRSE, medical response surge of it. We found a number of challenges with folks communicated to us about determining what that is, so to have kind of a level load across all coalitions. I mean, if we were to use just a number for a large coalition would be much easier than say, just a number for a smaller coalition. So we've identified and looked at different ways to do the surge target requirement. Remember, this is a surge target.

The MRSE no longer requires a mandatory calculation of those 5 different bed types, or requires HCCs to survey the current operating capacities of their facilities. We've had folks who

said, “Oh”, on the morning of it, the exercise! They're trying to go out and get these numbers and spend a lot of time and effort with numbers, and, as Dave mentioned earlier, we've mentioned on numerous occasions, this exercise is about communication and collaboration and coordination, not necessarily numbers. And it's not all about numbers. So we want folks to focus on those areas not necessarily spend a tremendous amount of time working on the numbers.

So, in the reporting tool coalitions will now enter the total number of licensed general and medical surgical beds within the jurisdictions as requested from the recipient. The reporting tool will automatically calculate the target number of surge patients required for the exercise based on the number of licensed general medical surgical beds in the coalition. We're hopeful that these changes will relieve some of the pressures faced by coalitions when they were required to calculate 20 percent of their staffed beds for the exercise. I know we've got some questions about that.

The new surge target requirement for a coalition is 10 percent of your licensed medical surgical beds. Next slide, please.

So this is the patient distribution summary table on your right. They revised one. We have streamlined this quite a bit. Coalitions will triage your patients into green, yellow, red, and black categories. Coalitions will indicate the number of patients that were cleared at the scene and did not require Emergency Medical Service transportation. The data collected in this table we use to calculate performance measure 19.

We heard a lot of from you, talked to folks about the patient distribution table. This is much more streamlined than it was, and hopefully it will help you all fill this out a little bit more completely, a little faster. We had a lot of challenges to go back to coalitions when we got the final product to work through some of these calculations. So this is the new revised patient summary table. Next slide.

This slide provides a high level overview of the universal language changes that have been made across all MRSE documents to match the language used in the 2024 - 2028 HPP cooperative agreement Notice of Funding Opportunity, or NOFO. Next slide, please.

I'm going to turn this back over to Mr. Dave Cernak to talk about MRSE flexibilities and alignment of our exercises with other requirements. Thank you.

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David Cernak: Excellent. Thank you, Kevin.

So, one of the other things that you know we get a lot of questions on is - how can I better incorporate other exercise requirements and meet other program requirements utilizing the MRSE? When we look at the MRSE, we looked at the NOFO and how the MRSE is going to fit into the fold. The NOFO is really focused on the recipients, with full incorporation of the health care coalition. So, if you look at every requirement in the NOFO, you'll see that every requirement in there has a role for the recipient and for the coalition to play.

When we've looked at the exercise section specifically, all the exercises in there obviously are directed to the recipient, so their job as a recipient is to ensure that those exercises are met. But the MRSE is the one that is truly focused on the coalitions, right? It's the one exercise of the 6 to 7 exercises that are listed out in the NOFO, that is to be planned, organized, and led at the

coalition level, right? It's the one that you guys get to take lead on and direct and develop to best function and best meet your needs, right?

So in doing that, there's all those other requirements that are in there as well, that can be folded in and met along the way. As you look at developing the MRSE you have the flexibility to work any of those other requirements in that you may have that any of your partners may have, that your members may have - like facilities that may be joint commission accredited, and things like that. They have exercise requirements. You may be able to develop and roll in some of those requirements as well.

What you can also do is look at some of the other partners that you have as well. So, emergency management, public health. They also have exercise requirements, and in order to help one again, improve that coordination collaboration, build those stronger partnerships, and at the same time, lighten your workload. You don't have to plan and execute the MRSE all by yourself. Bring in more partners, bring in more players, look for those opportunities. So if another one of your member organizations has an exercise requirement, fold that into the MRSE. Utilize the MRSE as the means to validate and demonstrate your capabilities at the coalition level with your plans, and at the same time allow those other partner organizations to leverage the same exercise to validate some of their other plans. That'll help you build stronger working relationships and make sure all of your plans are in alignment.

Emergency managers at the local and state level may have some great expertise in certain areas, and be able to bring some great opportunity into the MRSE for you, and allow you to exercise a scenario or exercise with certain resources you may never have had the opportunity to exercise with in the past. Local public health has a bunch of exercise requirements specifically coming down through the PHEP grant that they have to perform - things like infectious disease, biologicals - there's some other communication stuff in there as well that they have to do. Incorporate all that together, and, you know, say, kill 2 birds or kill multiple birds with one stone, but you know, kind of roll it up.

Lay out all the objectives for all this, all the separate exercise requirements that you may have, lay out all those exercise objectives, and then build the exercise in a way that's going to help address each one of those objectives. So as you go through your exercise, not just for the MRSE, making sure that you're meeting each of the exercise objectives, and you're able to collect the necessary data in order to hit the requirements and address their performance measures. But make sure that you've also incorporated those other objectives in there as well. That will allow you to bring in those other partners within just the HPP cooperative agreement.

There are those other exercises down the road as well. Cyber security extended downtime - there's workforce in there, there's patient movement. They don't have to necessarily be the biggest focus of the exercise, but if you are able to develop a component in the MRSE that will exercise an extended downtime event, right? It could be something that is part of the scenario as long as that exercise component allows you to validate the plan right or the current plan there, and determine if there's areas for improvement there, then that would count and meet that additional requirement right.

Like, I said, do the same thing with everyone else on this, on this little graph. Here, we kind of put the requirements in in boxes, right? Because they're kind of packaged up, we clearly lay out what the requirement is for each one of those exercises, what the objectives are for those and put them in a nice little package. But in order to be successful, we want you to think outside

those boxes. We want you to look for those points of connection and intersection between those different requirements in order to kind of bring them together, right? There's not necessarily a need to perform multiple exercises each year if you can do it all in one.

The MRSE is intended to be the health care coalition's opportunity to take lead and validate and practice and train all at one time, around what your focus is for that given year. I'm trying to think of a good example. If your focus for this coming year is going to be on communications, the focus of your MRSE exercise can really be on exercising and validating all those communication and information, sharing plans, right? The MRSE does not have to be purely focused on - I've got a bunch of patients here; I've got to talk to EMS; I've got to get them to a hospital; and I've got to have them evaluated in a hospital and then admitted into beds. That doesn't necessarily have to be the main focus of your MRSE. Your MRSE can focus in on whatever your priorities are, and what your requirements are for that given year.

You can make it a communication-centric exercise. You can make it a resource management exercise. You can make it kind of a partner exercise between healthcare, long term care and public health, and identify an intersection there based around a high risk or high threat scenario in your community. It all depends on what you want to focus on in a given year. As long as you address the specific objectives within the MRSE and the requirements and you hit those targets. That's what'll help you be successful in the MRSE, and that's what'll count. So, as you look for opportunities to bring in extra support, bring in extra players right, start by talking to your folks. Figure out what their additional requirements are, what their organization is looking to do that year, and find a way to bring it together. This way, you can work together, you can get other folks at the table, and you don't have to kind of plan the MRSE and execute and evaluate it all on your own. You do it as a group. Bring it together, strengthen those partnerships, build those bonds, improve connectivity, and go from there. And if at any point you need more help, that's when we turn back to the recipients as well, and we ask them for additional assistance.

We identified, like I said, four categories here, HPP, PHEP, CMI, CRI. But there are many more. For example, there's the FCC exercises, or something that has come up with NDMS, and the federal patient movement component, right? Looking at that as a potential opportunity. This is going to sound airport centric - there's the FAA exercises, where airports have to do mass casualty exercises in order to maintain their FAA credentialing or accreditation, or whatever it is. But they have to do mass casualty exercises at airports. There are other organizations out there across the state that may also have exercise components, right? So reach out. Talk to those partners, figure out what's going on, and look for ways to incorporate as many folks and as many players as possible. So this way you can have very unique, interesting, and well developed exercises. So with that, said, I know we're little over half an hour, but I definitely know I want to make time for lots of questions. We can get into more of these flexibilities and trying to think outside the box on office hours, but let's keep moving forward here.

Alright, Gbadero.

00:34:24.440 --> 00:36:09.150

Olugbadero Yerokun: Yes, thank you, Dave. I'll just provide a couple of next steps for the group here. If you have additional questions about the MRSE as you review the materials, and as you start planning for your exercise, please email the MRSE mailbox, which is MRSE@hhs.gov. We'll usually reach out, and if you want to have a one-on-one meeting with us, you can also request that, and we can set it up with you.

Next, we're holding additional office hour sessions next week from October 15th to the 17th. You can access office hours via the Zoom link - you can use the QR code on this slide to access the Zoom link - and the Zoom link is also available on the ASPR Readiness Bulletin. And please do feel free to email us if you're not able to access the link, we can get that directly to you. Next slide, please.

Okay. So now, we'd like to open the line for questions. Again, to submit a question or written question, you can use the chat. Or, if you'd like to ask a question verbally, please select the participants icon, raise your hand, and we'll ask you to unmute.

And before we get started I just want to confirm- I've seen these questions in the chat - I want to confirm that we'll share this presentation, the recording, the transcript and all unanswered questions after the call. So you will receive those meeting materials.

Dave and Kevin. I've tried to group the questions based off topic so I could guide us that way to start answering questions in the chat if that works.

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Kevin Sheehan: That works, sure.

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Olugbadero Yerokun: Okay, first thing is CAAMP. So CAAMP was mentioned, I dropped the: the meaning of the acronym in the chat. So, just want to address that HCCs don't have access to CAAMP, but the recipients do. There's a question about explaining what CAAMP is, how we'll be using that. And Pete has also dropped information in the chat about CAAMP replacing the CAT. So, if you could just clarify, why we're using CAAMP at this point in time, how it's applicable to HCCs and recipients.

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Kevin Sheehan: Is that to me? Peter – want to explain and address this? I know he works on it.

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Peter Telaroli: Yeah, I'm happy to. I'm happy to do that.

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Kevin Sheehan: Okay, Peter, if you could, that would be great, sir.

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Peter Telaroli: Yes, so again, CAAMP, the cooperative agreement accountability and management platform, is basically a web-based platform where we are currently building functionality to replace the coalition assessment tool as that is no longer going to be used going forward.

There is not a current timeline on when that will be available or functional. But we are currently putting MRSE documents in there, and so if you need those MRSE documents, we request that you talk to your recipients. They have access to CAAMP at the moment. But going forward in the future it will be the replacement for the coalition assessment tool.

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Kevin Sheehan: Great thanks, Peter.

00:37:43.230 --> 00:38:02.999

Olugbadero Yerokun: Yes, thank you so much, Pete. Okay, I'll move into the first question that was asked. Can the evacuation of a behavioral health facility - so this is a real world situation, 90 patients, 10 receiving facilities - be used to meet the MRSE requirement?

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Kevin Sheehan: I would say, if it's a real world event, at least talk this over with your recipient and your HPP Project Officer. If it's region 9 or 8, then let me know. If it's 10, let Dave know. But if you don't know your HPP Project Officer, send us a note at the MRSE inbox, and we can talk you through that. So specifics like this, we definitely want to work with you and make that happen. But we need a little bit more detail. And we can definitely talk with you more about it. Dave, anything to add about that, sir?

00:38:37.670 --> 00:41:55.490

David Csernak: Yeah, I'll just say, from a general standpoint, that yes, we understand. Real world responses happen, right? The MRSE is the only exercise that we really have very specific objectives and information, kind of data collection points, for specific requirements. The other exercises that are in the NOFO provide a lot more flexibility. The exercise is really there to validate the plan that is being written as part of the NOFO or being updated as part of the NOFO. So it's just, do the assessment, update the plan, conduct an exercise that validates the plan, evaluate it, assess it. Write your AAR, and the requirements met when it comes to the MRSE. There we did lay out specific requirements, and the data collection requirements, as well as the surge target requirement.

The 10 percent we adjusted it based on a lot of the feedback that you guys provided to us, and we didn't do it in a bubble, right? We actually spoke with coalitions. We spoke with a bunch of DPHPs at the state level, got a lot of feedback on it, and also then compared those numbers, as we were kind of trying to figure out what the right number was going to be.

I think it was at least half a dozen real world responses looking at AARs and patient totals to try and find a number that was really in line with what real surge numbers were looking like in various jurisdictions to various types of response across the country. So, if you want to use the MRSE for real world response, you have to make sure of a couple of things.

One, do the response, collect the data, make sure you're familiar enough with the MRSE. Read the Exercise Guide. Understand all the nuances of it. So when a response happens, you know which data and what information need to be collecting. You need to be able to complete the tool and report on all the components within the tool in order to submit it. You can't submit half a tool.

And then you need to make sure that the surge there, was actually hitting or exceeding that surge target. Like I said, I caution you. It's not just a suggested number. It's the surge target that you're going for. If there's a very specific opportunity or something comes up, or you're targeting a very targeted capability and you want to look for a possible opportunity to kind of deviate or come in less for a certain reason, then, we can have that conversation ahead of time. But that's the number that you really need to be striving to hit. So if you're only coming in at, you know,

half that, or less than half of that, you know you're not hitting the surge target, it's not going to work, right? So you're just going to have to continue planning the exercise.

As long as you hit the objectives, and you can report on all the information, then you can submit a real world response. But again, do the response. Write the AAR. Make sure you got all the data you need, and then talk to your FPO. Talk to your recipient and make sure it's going to meet the mark. Because, as a recipient, if the state says no, then it's obviously going to be no. So everybody has to be on the same page for it to count. So I hope that helps.

And I see we've got some hands up as well. Do you want to go to folks on the phone?

00:41:55.750 --> 00:42:25.719

Olugbadero Yerokun: Before we go to Chad and Paul, I do see their hands raised, before we go to them you had mentioned the 10 percent requirement. Just want to get those questions out of the way. So, those ask for additional clarification on, is it 10 percent of the licensed beds of the participating facilities? Or is it 10 percent of the whole region?

And then the second question is, what do you do if you don't hit that 10 percent target?

00:42:27.080 --> 00:45:14.589

David Csernak: Alright, so when we were looking at a way to come up with a much more consistent and repeatable number and calculation, looking at the staffed beds we had, we got a lot of feedback on the difficulties surrounding staffed bed numbers and the significant amounts of fluctuation. Whether it was on the workforce reasons or hospital operational reasons, but lots of fluctuation. On that staffed bed piece and the difficulty of collecting individual bed types on that staffed bed piece for simplification. Looking at licensed numbers, the state licenses a certain amount of beds for each facility. That number is fairly consistent, and rarely fluctuates from year to year, so the number should be pretty consistent from year to year with very little to no variation.

But also because of that, we also then said, "well, let's just focus on one bed type, right?" So the licensed general medical surgical bed is just that general medical, inpatient kind of you know, general ward bed in your facility.

We looked at the licensed bed numbers, and then we reduced it to 10 percent, and that will also bring those numbers way down in some jurisdictions. When we calculated it out and then looked at previous MRSEs, it cut that number of what they were using for their 20 percent of staffed beds by 50 percent. I mean, some of it was a huge, huge drop, others it came down 20 to 30 percent. But there was a significant decrease, I think across the board for most health care coalitions in doing it this way, and it was a lot easier for the state to pull that number, provide that number, look at 10 percent of it, and then focus on that. So it's 10 percent of the licensed beds, not the staffed beds, but the licensed beds.

Also keep in mind, too, this calculation is not dependent on who's playing in the exercise or what the scenario is. This is a standard baseline calculation to help you determine a surge target for whatever the exercise is, whatever the scenario is, no matter who the players are, it's within your health care coalition's jurisdiction.

I think there was a question there, too, about pediatric facilities, pediatrics or specialty care facilities, right? Just look at your general acute care, medical facilities, your general acute care hospitals. Don't look at your specialty care facilities, don't look at your pediatrics, your mental health facilities, your rehab facilities, things like that. Just focus on your general acute care hospitals and those licensed medical surgical beds within those facilities. And that's what the state is going to use to calculate that total. Hope that answers the question.

00:45:15.420 --> 00:45:22.239

Olugbadero Yerokun: Thank you, Dave. We can go to the raised hands now, I think, Chad, you had your hand raised first.

00:45:23.530 --> 00:46:37.449

Chad Cossey: Yes, thank you. And good morning, everyone. Hi Kevin, hi Dave. My question, please let me elaborate before. You guys talk about surge. But what kind of surge are you talking about? And I'll kind of explain. Couple years ago we, we declared locally for RSV, which is more infectious disease, and that caused a surge. As we are filling out the tool, the MRSE tool, I can tell you that it began feeling like that puzzle piece where it looks like it fits but it's not until you build around it you find out that wasn't the right puzzle piece, the tool. I hate to say it feels more like it's built around if there's an explosion or a release of a chemical and even though that, you know, could happen in real life for a lot of us, we have to simulate that, that creates a workflow for us where we have to build after we do the numbers, I think, for Orange County, it's like 333 patients. I've got to come up with 333 simulated patients in order to surge the system. So my question is when you guys say, surge exercise, what surge are you talking about?

00:46:39.040 --> 00:47:47.930

Kevin Sheehan: Hey Chad, well, good day to you, sir. It wasn't written in the perspective of you had a chemical explosion, and you had all these types of things, or a mass casualty incident due to a shooting or something like it was just, you know, we didn't have anything specific. We wanted to leave that really up to you all to determine what is the most logical type of surge event we would have in our coalition. Really, we've linked it back to your HVA. We want you to pick something within your top HVA risks to your coalition, and then, develop what that may look like to you. It could be a multiple type of event, or it could something else.

Orange County in terms of you know MCI type opportunities, there's a lot there for you, but so that wasn't written with any intent to consider it to be a chemical or anything like that type of event. Is that helpful at all?

00:47:49.420 --> 00:48:30.991

Chad Cossey: Yeah, I mean it helps describe the tool. I can just tell you, going through it, it felt like the tool was more almost kind of like statistics, right? You can get the statistics to say anything you want if you know what statistic question to ask. It felt more geared towards a mass casualty incident. I'm not claiming that you guys intended that or anything, I'm not \that's not the purpose of the question. I'm just trying to make sure that when I design an exercise per se, that I can make sure that it kind of fits the tool and that we're all working together. With the infectious disease surge, it felt a little wonky to try to get those numbers to fit.

00:48:31.310 --> 00:48:33.510

Kevin Sheehan: And I remember working on that with you, yes.

00:48:33.510 --> 00:48:34.210

Chad Cossey: Yes.

00:48:34.210 --> 00:49:44.869

Kevin Sheehan: It was the surge and we did work with you. And you know, and hopefully, the streamlining changes we've made in this tool will make it a little bit easier for you all to do. And if you did have a real world event, that's what we really want to talk to you about ahead of time before. For example, we wouldn't want someone to say, Oh, we're at the end of, you know, June 15th and we use this real world event. That really wasn't much of a surge at all. And we're like, well, wait a minute. How, where did you get? How did you get any kind of approval? To go about doing this is a requirement from our program for every coalition to do so. These are, you know, some checks and balances we want to have in the system, so that we don't have any surprises down the road. But we also really want to work with you. We're really interested in what you have a different kind of event. Maybe it doesn't meet that surge target, Dave, alluded to the fact. We'll work with you. We'll talk with you. We want to be able to understand and help you get as prepared as you possibly can. So that's kind of where we're at, Dave. Anything to add, sir?

00:49:45.610 --> 00:52:57.380

David Csernak: Yeah, I was going to say, Chad, we tried to keep as much flexibility in the nuances of the exercise as possible. Like Kevin talked about. We've tried to refine the tool, to just collect the certain data elements that we would be able to utilize and with consistent reporting, that'll allow us to provide a lot more feedback and a lot more input back to you guys at the state and local levels from year to year. But when we talk about surging right, think about your different plans and what it might take to surge that plan, and challenge that plan with a scenario. So you're not just necessarily surging an emergency department, right? But maybe you're surging other certain components of your response capabilities within your community.

Say that there's an incident that has a large need for decontamination, right? So there's a decontamination event. But those patients might not necessarily need inpatient care, but they all require some sort of support and assistance during the response. It sounds bad if you looked at the chart when Kevin was showing the updates to the patient tracking table. It's kind of broken down by triage category, right? There are states that have been working on developing mass fatality management plans, right? Especially in major cities that have been working on that as well, you know, looking to say, those individuals that don't survive an incident. Those are also patients that need to be managed. So you can incorporate an element of that.

It's unfortunate as well, but there's also a strong need and a lot of big responses or a lot of responses for mental health support and services, maybe not just for the victims, but also maybe for the responders, right? If you have one of the critical incident stress management teams or the behavioral health support teams, you can add an element in there and say, we're going to activate the plan to mobilize them in support of the 100 responders that came to this scene because of the type of response, so different ways to look for bringing in plans, activating and validating your plans, and looking at the number of individuals that would be supported by those plans. And that's kind of how you can bring those numbers up and address it based on

the scenario, right? It can be somebody. It's on the chat here about skilled nursing facilities again.

As well, you know if it's an evacuation you can do an evacuation scenario at a skilled nursing facility. Or if you have an FCC exercise, you can be bringing patients and surging a skilled nursing facility in your community, from skilled nursing facilities outside your community, right? The numbers there, you know that, or that could just be a piece of it, right? So, different ways to surge different plans in your jurisdiction will help you get to those totals. Just look at what your risks are in your scenarios, and see what you can do to bring in those different plans and build some patients to manage. And that's how you can work up those surge numbers and surge those different components of your coalition. I hope that helps.

00:52:57.560 --> 00:52:59.180

Chad Cossey: Yes, thank you. Copy that.

00:53:00.290 --> 00:53:25.589

Olugbadero Yerokun: Thank you. Before we get to Paul and David, Dave and Kevin, just want to make sure that this is very clear. So the question is when you say 10 percent of licensed beds, is it 10 percent of licensed beds in an entire region? Or is it 10 percent of licensed beds of participating facilities.

00:53:25.880 --> 00:53:51.700

Kevin Sheehan: Well, let me let me give a shot, David. It's 10 percent of licensed medical surgical beds in your coalition. So 10 percent from general acute care hospitals, 10 percent of licensed medical surgical beds for general acute care, hospitals in your coalition. Dave, anything more to add?

00:53:51.700 --> 00:54:06.880

David Csernak: And that's it. It doesn't matter who's participating. That's what that number is calculated ahead of time based calculations done ahead of time, and then that number is given to you to kind of, then go forth and do good planning for the exercise.

00:54:06.880 --> 00:54:10.860

Olugbadero Yerokun: Thank you both. Paul Pestel, you have your hand raised.

00:54:11.910 --> 00:54:41.199

Paul Pestel: Yes, thank you. Are we limited to the 10 percent? Because I know that we for many, many years, we've always done 20 percent. Everything that we've ever had to do is 20 percent. And I think it was a question - the Joint Commission requires you to do 20 percent? Is it acceptable to do 20 percent rather than the 10 percent so that we don't have to do multiple exercises to meet everybody's requirements?

00:54:43.430 --> 00:54:48.180

Kevin Sheehan: Paul, this is Kevin. Where are you from, sir? Just interested.

00:54:48.180 --> 00:54:49.100

Paul Pestel: Arkansas.

00:54:49.360 --> 00:54:57.059

Kevin Sheehan: Arkansas. Okay, Dave, why don't you take this? Paul, sorry I never met you. I didn't know who you were.

00:54:57.060 --> 00:54:58.040

David Csernak: No problem.

00:54:58.040 --> 00:55:00.040

Paul Pestel: We met in Orlando many years ago.

00:55:00.040 --> 00:55:01.320

Kevin Sheehan: Oh, okay. Paul.

00:55:02.300 --> 00:56:33.740

David Csernak: Paul, we will absolutely support any challenge that you want to pose in your in your jurisdiction. But if you guys want it, that's why I said we didn't want to say there was a 10 percent surge requirement right? Because we didn't want it to sound like it was so restrictive that it had to be that was the exact number of patients, right? So that's like your surge target. If you want to exceed that based on the scenario based on a separate requirement, or based on the needs of the jurisdiction, or just because you're just like, you know what I really want to build an exercise that's going to just break the system, right? If you want to exceed that 10 percent, absolutely, you can do that.

We tried to get the number down enough that folks would be able to hit it, and this way for consistency. We could say, you know, this was the minimum surge target across the board for when we did data collection and analysis. But by all means, if you want to say we calculate there were some coalitions, I think, that we calculated the number and based on their geography and then total number. Their surge target was like less than 10 patients. And we're like, okay, it makes sense because their coalition only has, like one hospital and a critical care hospital, right? So the numbers were really low. So, a surge of 10 may actually really challenge them. But if they wanted to go to, you know, make it 25, or 50 patients to really challenge them. Absolutely, it is entirely up to you guys as long as you target to at least hit that 10 percent.

00:56:34.920 --> 00:56:36.460

Paul Pestel: Alrighty. Thank you. Appreciate it.

00:56:36.460 --> 00:56:37.540

David Csernak: Absolutely, sir!

00:56:37.900 --> 00:56:39.240

Kevin Sheehan: Thank you. Paul. Thank you.

00:56:39.240 --> 00:56:42.970

Olugbadero Yerokun: Okay, David Benn, you had your hand raised. Please go ahead.

00:56:43.810 --> 00:56:53.970

David Benn: Yeah, I don't want to hit the bed question. I've got more than just one. But since we're still on the beds, so critical access hospitals also do not count then?

00:56:53.970 --> 00:57:00.640

David Csernak: Correct,. Yep, critical access wouldn't count. Just look at those general acute care facilities.

00:57:00.640 --> 00:57:09.039

David Benn: With your general beds like at my hospital, the general beds include our post critical care, is that correct?

00:57:09.340 --> 00:57:15.580

David Csernak: Most of the time they're broken out. I've seen, and again talk to the state and see how they license them.

00:57:15.590 --> 00:57:19.050

David Benn: Licensed, critical care and non-critical care. That's it.

00:57:19.050 --> 00:57:54.590

David Csernak: So that's how they break it down. So yes, you can work with them if they're able to make that determination and bring it down a little bit because most of the time, when we look at the way states break them out, you'll see medical surgical. Then you'll see ICU, pediatrics. Sometimes, you'll see psych rehab. You'll see a bunch of other types of beds listed out there, but some states don't go that detailed, right? So if you've got a question, we're here We can work it out with you, or just work with the recipient and say, hey, can we break out those additional ICU beds and stuff just to focus on those inpatient beds.

00:57:54.590 --> 00:58:46.520

David Benn: Because, like, we have 3,334 beds that would have all the other stuff if I had ones that were just medical surgical had nothing else added, I'd have 30, so it doesn't make a lot of sense, because most post then. More to fun stuff, so the big problem we had last time was getting the performance measure 19 figured out because the questions were a little bit crazy. And now it's much simpler. But even now it still says, number of existing patients and surge patients required admission. But when you go to the input information it doesn't talk about existing patients. So the performance measure doesn't match up to what you're collecting unless we need to change the wording. And then there's another thing with wording too like objective 4. How can I prove that I've decreased morbidity and mortality because I can't.

00:58:49.320 --> 01:00:16.810

David Csernak: Okay, we'll take that for note, and we can dive into that a little bit deeper during the office hours, because we were going to kind of do a little bit more of a deep dive into the tool

and the reporting. So we can make a note of that and jump into those next week when it comes to those objectives. The objectives kind of align with several of the performance measures right? So it's really driving towards those performance measures. So once we kind of look at those numbers, I guess that's kind of the easiest way to kind of start to look at it. But when you're looking at evaluating, and you're having your evaluators kind of look at the materials, or sorry, the exercise objectives, and then the actions that are being taken. We tried to lump some of the objectives together and kind of bucket them down to reduce the overall number of objectives. So this way, it'll allow you greater opportunity to add more of your own objectives into the exercise that allow you to kind of focus and target on your exercise. Because some coalition said, well, you've already given us so many objectives. How many more objectives, can we add? We've become overwhelmed with too many objectives, and then it's too hard to evaluate. So, we tried to refine it a little bit to reduce the number right, and try to bucket them in on those performance measures to give you more flexibility with your own objectives. But we can talk that through a little bit in more detail during the office hours. If that'll work for you.

01:00:16.810 --> 01:00:49.210

David Benn: Okay, and kind of a holdover from yesterday because I was going to ask it yesterday. But it was more appropriate today. The HSEEP is designed to highlight capabilities, and some people have trouble not having an understanding on how to build capabilities and to work them correctly with their plans. People are asking for templates, and you said that they should have a lot of plans, but they don't necessarily have capabilities built in a way that would fit into the HSEEP After Action to help them out. And then, since of course, we're at the end and I'll probably see in office hours, there's a few dead links and things that aren't linked correctly in the tool, and a few spelling. I'd be happy to pull.

01:00:50.890 --> 01:01:41.330

David Csernak: We can take a look at that when you're looking at the capabilities, totally get it right? You can look at the existing capabilities that are out there that we have for healthcare, or you can just look at the core functions, too. The core functions align in the beginning of the tool, we have you highlight which core functions that you're going to be focusing on during this exercise. And just for everyone's awareness, if you're looking, the core functions are also laid out in detail in the NOFO starting on page 12.

But if you can address it that way rather than necessarily getting into core function, or sorry with that necessarily getting into the other capabilities, you can target those core functions. But we'll walk through all of that as well when we get into the tool a little bit more. I'm sorry, was there another part of your question, David, that we missed?

01:01:43.350 --> 01:01:50.509

David Benn: I was just offering that in the tool, some linked spots aren't linked, and some words aren't spelled.

01:01:50.810 --> 01:01:53.839

David Csernak: Oh, wait, I'm sorry. What was that last part about the office hours, or what?

01:01:55.512 --> 01:02:03.369

David Benn: There's some places in the tool that look like they're supposed to be linked that aren't linked correctly, and some I'll show you.

01:02:03.830 --> 01:02:06.350

David Csernak: Gotcha. Okay, sounds good. Thank you.

01:02:06.350 --> 01:03:01.439

Olugbadero Yerokun: Yes, thank you all so much. So we are at the end of the call. We're just a little a few minutes over, but I'll go ahead and wrap this up. So, thank you to everyone that's attended. We're really happy that you were able to join the call and thank you so much to Dave and Kevin for hosting this call for us and fielding the questions. Like we said before, we have office hours, please go ahead and join office hours. David Benn, if you're still online, please do send those links to the MRSE mailbox that are not working for you, so we can take a look at that. Otherwise, we'll see you on the office hours call. So with that. Thank you. Everyone have a good rest of the day.