U.S. Department of Health and Human Services

Office of Inspector General

Selected Health Care Coalitions Increased Involvement in Whole Community Preparedness But Face Developmental Challenges Following New Requirements in 2017

OEI-04-18-00080
April 2020

oig.hhs.gov

Christi A. Grimm
Principal Deputy
Inspector General

Report in Brief
April 2020
OEI-04-18-00080

U.S. Department of Health and Human Services
Office of Inspector General

Selected Health Care Coalitions Increased Involvement in Whole Community Preparedness But Face Developmental Challenges Following New Requirements in 2017

Why OIG Did This Review

Health care coalitions (HCCs) help prepare their community health care systems to respond to public health emergencies, such as natural disasters. HCCs are member-led and are composed of health care entities and other response entities that voluntarily work together to coordinate an emergency response. The Office of the Assistant Secretary for Preparedness and Response (ASPR) supports HCCs through the Hospital Preparedness Program (HPP). In 2017, the HPP required HCCs to include four core member types (hospitals, public health, emergency medical services, and emergency management) and other diverse, ancillary member types (e.g., long-term-care facilities, home health agencies) that are critical to addressing the unique preparedness needs of HCCs' respective communities. Additionally, the Centers for Medicare & Medicaid Services (CMS) suggested that health care entities join HCCs as one way to meet its emergency preparedness Conditions of Participation, with which CMS required compliance starting November 2017.

This is not a review of the Federal, State, or local government response to the novel coronavirus (i.e., COVID-19) public health emergency.

How OIG Did This Review

We selected a purposive sample of 20 HCCs and the corresponding 20 HPP awardees that received 2017 HPP funding. We conducted interviews, administered surveys, and collected documentation from each HCC and HPP awardee from November 2018 to January 2019. We analyzed responses and documentation to determine the extent to which HCCs expanded their membership; to identify HCC benefits and challenges for coordinating with members; and to determine the extent to which ASPR requirements and guidance facilitate HCCs' and HPP awardees' ability to increase whole community preparedness.

What OIG Found

Key Takeaway
More diverse health care entities are participating in beneficial HCC activities. However, new entities did not always fill gaps in preparedness and response. Further, training new ancillary entities pulled resources from other priorities and reduced the incentive for hospitals and other core members to participate.

Nearly all 20 HCCs in our review have expanded their membership since ASPR and CMS required compliance with new preparedness activities in 2017. According to most of these HCCs, this expansion was driven primarily by new diverse types of entities seeking to meet the CMS emergency preparedness Conditions of Participation. Further, all selected HCCs reported that their members take part in HCC activities that benefit whole community emergency preparedness.

However, HCCs also reported that expanded membership presents challenges. For example, some HCCs reported adding new ancillary members without regard to their community's needs. Further, many HCCs reported concentrating their limited resources on developmental activities for these new ancillary members, thereby lessening resources available for other HCC priorities. Moreover, HCCs expressed concerns about their ability to continue to incentivize core members' participation in HCC activities.

Additionally, while HCCs and HPP awardees generally found ASPR guidance beneficial, we found that some HPP requirements and some ASPR guidance are not clear. Specifically, unclear requirements and guidance included (1) how an HCC should strategically grow membership, and (2) the flexibility that ASPR allows in meeting HPP membership and other requirements. This lack of clarity contributes to HCCs' challenges and may limit HCCs' ability to prepare for a whole community response to a range of public health emergencies, including emerging infectious diseases.

What OIG Recommends and How the Agency Responded

To further improve HCCs' preparedness for a whole community emergency response, ASPR should (1) clarify guidance that HCCs' membership should ensure strategic, comprehensive coverage of their communities' gaps in preparedness and response; (2) continue to work with CMS to help health care entities comply with the CMS emergency preparedness Conditions of Participation; (3) identify ways to incentivize core members' participation; (4) clarify to HPP awardees the flexibility available in meeting requirements. ASPR concurred with all four recommendations.

TABLE OF CONTENTS

BACKGROUND

Objectives

1. To determine the extent to which selected health care coalitions (HCCs) expanded membership to include diverse community and health care entities to prepare for whole community emergency response.
2. To determine HCC benefits and challenges coordinating with members to prepare for whole community emergency response.
3. To identify the extent to which the requirements of and guidance for the Hospital Preparedness Program (HPP)—administered by the Office of the Assistant Secretary for Preparedness and Response—facilitate the ability of HCCs and awardees to prepare for whole community emergency response.

Rationale for this Study

Public health emergencies, such as hurricanes, call to action diverse community and health care entities, to include law enforcement, public health agencies, and health care organizations. Based on past experience, these entities do not always coordinate well and often have different community and organizational goals.

For example, in September 2017, Hurricane Irma left a swath of devastation from the U.S. Virgin Islands and northern Puerto Rico to the Florida Keys and central Florida. Tampa Bay health and medical emergency responders stated that their coordination with home health agencies, nursing homes, and assisted living facilities before the hurricane had been inadequate.[1] Specifically, their emergency response plans underestimated the number of patients who would evacuate from these facilities and seek care at hospitals or special-needs shelters during the storm. As a result, hospitals and shelters lacked enough supplies (e.g., oxygen tanks and regulators) to care for these patients.

ASPR's Hospital Preparedness Program

The United States has been funding efforts to lessen the effects of public health emergencies since the enactment of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002. The U.S. Department of Health and Human Services' Office of the Assistant Secretary for Preparedness and Response (ASPR) is in charge of the medical and public-health aspects of U.S. preparedness, response, and recovery. ASPR oversees the HPP, which is a key Federal funding source of readiness for regional health care systems.[2,3]

The HPP does not fund HCCs directly. Instead, the HPP funds HCCs through cooperative agreements with State, territorial, metropolitan, and Freely Associated States' government organizations (hereinafter referred to as "HPP awardees") to promote community coordination.[4] For example, HCCs provide benefits (networking, training, etc.) to incentivize these entities to work together voluntarily to prepare for and coordinate whole community public health or medical emergency responses.

Since 2002, the HPP has funded approximately $5.9 billion to HPP awardees to build health care system preparedness and response capacity. As of the project cycle that began in July 2017, ASPR funded approximately 476 HCCs through 62 HPP awardees.[5] Cooperative agreement funding to support HCCs was $231.5 million in the 2019 budget period.[6]

HCC Purpose and Membership

Over time, the HPP's recipients and requirements have changed.[7] Specifically, starting in 2002, the HPP funded individual hospitals to purchase equipment (e.g., ventilators, pharmaceutical caches). From 2012 through 2016, the HPP funded awardees to develop health care system capabilities in their jurisdictions. During this project period, HPP awardees had the choice to fund individual hospitals for preparedness activities, fund a coalition of hospitals and other emergency responders with a role in medical surge (i.e., fund an HCC), or fund both.

With the *2017–2022 Hospital Preparedness Program (HPP)—Public Health Emergency Preparedness (PHEP) Cooperative Agreement* (hereinafter referred to as the "2017 Cooperative Agreement"), the HPP began requiring awardees to use all HPP funding to develop, mature, and operationalize HCCs for whole community emergency response. In the 2017 Cooperative Agreement, the HPP temporarily permits awardees to provide some direct funding to individual health care entities for regional preparedness efforts if they previously have done so.[8] However, as HPP awardees gradually reallocate funding to the HCCs, these individual health care entities will work with the HCCs to receive HPP funding for projects that ensure regional coordination and collaboration.[9] The *Hospital Preparedness Program Cooperative Agreement* that went into effect in July 2019 (hereinafter

referred to as the "2019 Cooperative Agreement") reiterates that HPP awardees should provide a greater percentage of their total award to HCCs each year over the 5-year project period.[10]

According to the 2017 Cooperative Agreement, HCCs coordinate and incentivize entities to work together to prepare for a whole community emergency response that impacts the public's health.[11, 12, 13] Such emergencies include hurricanes and flooding that requires alternative locations for medical services for affected citizens.

HCCs are member-led and are composed of health and other response entities that voluntarily work together to coordinate an emergency response. HCC members prepare for a response through strategic planning, health care system preparedness and response gap identification, operational planning and response, information-sharing, and resource coordination and management. HCCs also serve as the coordinating entity between individual health care entities and jurisdictional incident management during whole community emergency responses.[14]

The 2017 Cooperative Agreement requires that each HCC include, at a minimum, four types of health care and emergency response entities, which ASPR has identified as being a core part of whole community emergency response (hereinafter referred to as "core members"). The inclusion of core members ensures that HCCs have members with the expertise and authority necessary to adequately carry out HCC responsibilities. The four types of core members are:

(1) hospitals;[15]

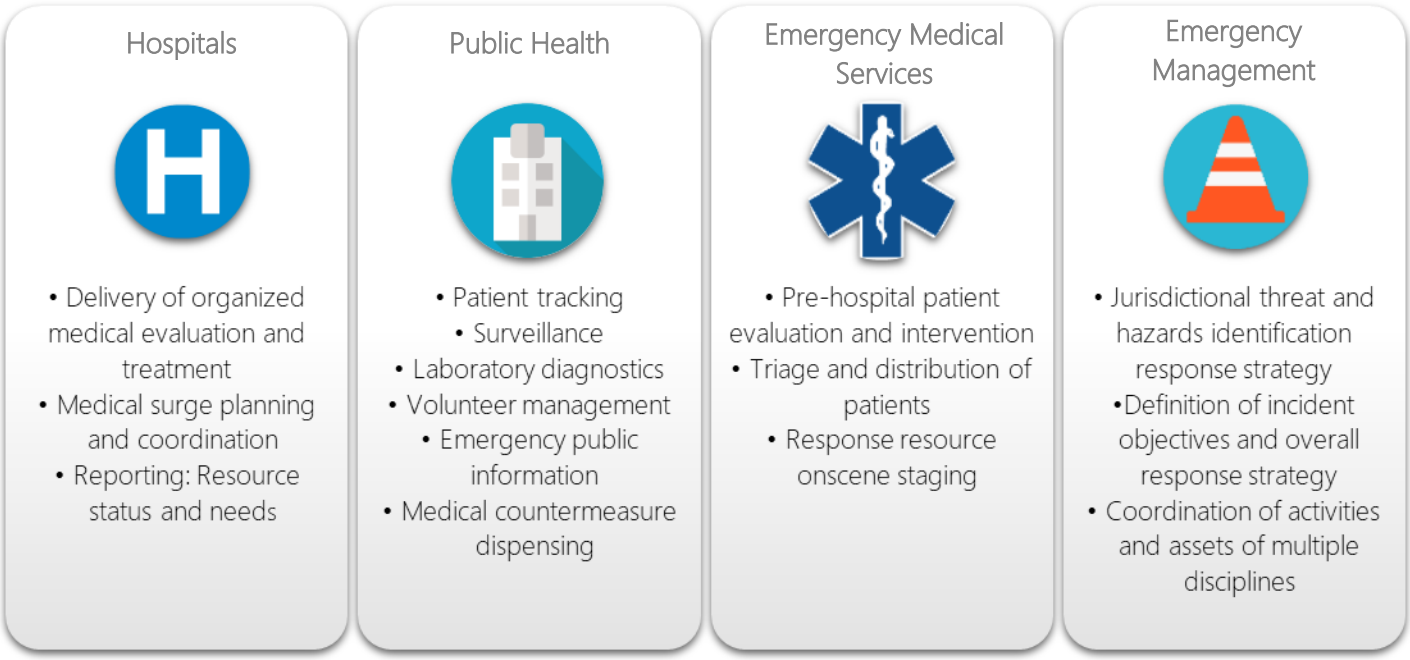
(2) public health agencies;

(3) emergency medical services;[16] and

(4) emergency management organizations.

See Exhibit 1 for examples of core members' roles in whole community emergency response.

Exhibit 1: Core members have different but complementary roles in local emergency response



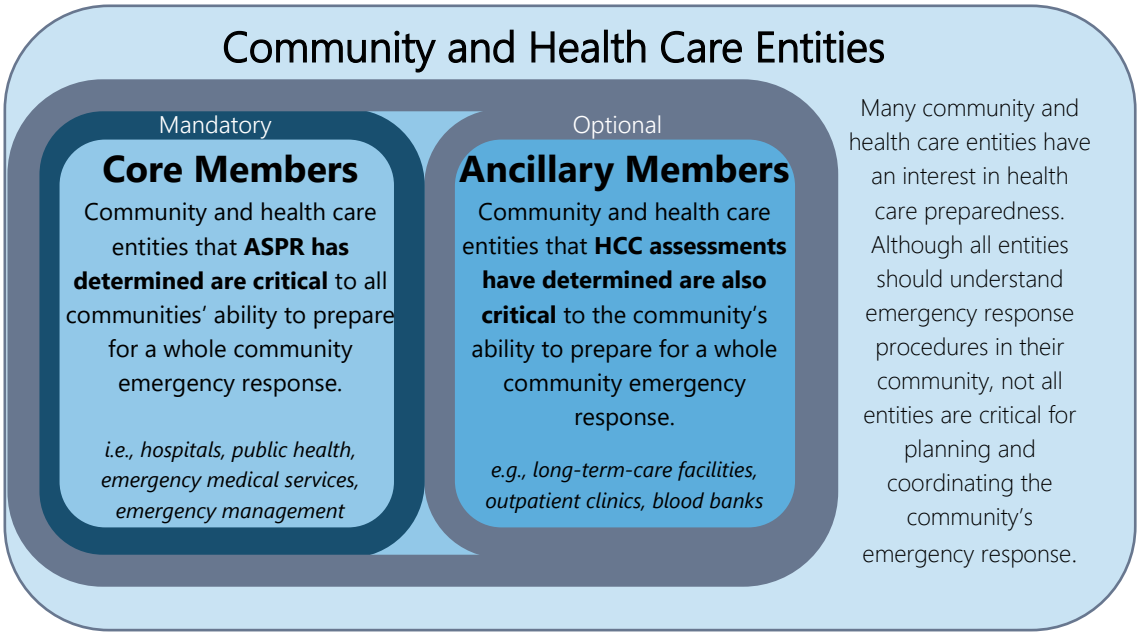
Source: HHS, *Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large Scale Emergencies,* September 2007. Contract Number 233 03 0028. Accessed at https://www.phe.gov/Preparedness/planning/mscc/handbook/Documents/mscc080626.pdf on May 24, 2018.

Additionally, the 2017 Cooperative Agreement requires HCCs to diversify membership beyond the four core member types. Specifically, each HCC must collaborate with diverse community and health care entities to ensure that it has the necessary resources for a successful whole community emergency response. According to ASPR officials, in addition to admitting core members, HCCs are free to admit any other entity type as a member. These non-core HCC members are hereinafter referred to as "ancillary members." Although there is no formal requirement for HCCs to use the jurisdictional health care system preparedness and response risks and gaps identified via the HPP-required Hazard Vulnerability Assessment to inform their membership, ASPR officials have stated that HCCs could do so.

ASPR's document *2017–2022 Health Care Preparedness and Response Capabilities* (hereinafter referred to as "ASPR's Capabilities Document") states that HCCs should include enough members to ensure adequate resources but also notes that too many members may make the HCC unmanageable. ASPR's Capabilities Document also lists other health care

entities as possible ancillary HCC member types. These entities include dialysis centers, behavioral health agencies, home health agencies, pharmacies, and blood banks.[17] Additionally, depending on community needs, any community entity with a stake in health care preparedness may join an HCC. For example, a rental car company willing to supply patient transport may be an appropriate ancillary member for an HCC in a community that has identified limited ambulance service as a response gap. See Exhibit 2 for ASPR's suggested HCC membership structure.

Exhibit 2: HCC membership should include community and health care entities that are most important to a community's ability to prepare for response



Source: OIG analysis of 2017 Cooperative Agreement and discussions with ASPR officials, 2019.

To manage the number of members in an HCC, and to keep the HCC's content and activities relevant to members, ASPR's Capabilities Document also recommends that an HCC form a committee structure. For example, if an HCC has multiple entities of the same type, the HCC may work with those entities to form a committee. A committee representative may serve as the HCC member and act as a liaison between the HCC and the other entities of the same type. If an HCC uses this committee structure, each community and health care entity does not have to be an HCC member to become integrated into whole community emergency response plans.

Oversight of HCCs

ASPR does not directly oversee HCCs or monitor individual HCCs' progress toward whole community emergency response. Instead, ASPR oversees the

HPP awardees, who in turn oversee the HCCs and report on HCC progress and performance to ASPR. HPP awardees interpret requirements in the Cooperative Agreement and develop work plans for how they and their HCCs will meet the Cooperative Agreement requirements. According to ASPR officials, HCCs and HPP awardees have flexibility in how they meet Cooperative Agreement requirements. If an HCC or HPP awardee has difficulty in developing a plan to meet a Cooperative Agreement requirement, ASPR will provide additional guidance and negotiate alternative ways to meet the requirement.

ASPR Guidance to HCCs and HPP Awardees

To help HCCs and other health care entities in their planning, ASPR's Capabilities Document includes aspirational goals, or aspirational capabilities, for health care system readiness.[18] According to ASPR, because these capabilities are aspirational, HCCs and HPP awardees should not expect to achieve them solely through HPP funding. However, the Cooperative Agreement requirements are intended to help push HCCs toward these aspirational goals. ASPR also identifies activities that HCCs and health care organizations can perform (but are not required to perform)—to help achieve each capability. See Appendix A for a summary of the four capabilities related to health care preparedness and response and an abbreviated list of 2017 Cooperative Agreement requirements associated with each capability.

Additionally, ASPR provides several other types of guidance both to HCCs and HPP awardees regarding how to prepare for a whole community response and how HCCs can meet the Cooperative Agreement requirements. Through ASPR's Technical Resources, Assistance Center, and Information Exchange (TRACIE) website, HCCs and HPP awardees have access to academic literature, exercise templates, facility-specific emergency plans, and other technical assistance. ASPR also conducts periodic teleconferences and webinars and sends out weekly newsletters about ASPR's HPP activities. Further, ASPR's regional Field Project Officers provide tailored technical assistance and general guidance to HCCs. For example, Field Project Officers can offer HCCs guidance on how to meet Cooperative Agreement requirements or negotiate alternative ways to meet these requirements. Additionally, Field Project Officers conduct site visits of HPP awardees and HCCs. During site visits, they monitor and evaluate (1) HPP awardee progress in meeting work plan priorities and (2) HPP awardee and HCC activities to meet Cooperative Agreement requirements.

ASPR also provides guidance to HCC members on how to meet new Centers for Medicare & Medicaid Services (CMS) emergency preparedness Conditions of Participation (CoPs). According to ASPR officials, ASPR has

collaborated with CMS to develop resources to support health care entities in complying with the emergency preparedness CoPs. These resources are available to HCCs and their members on the ASPR TRACIE website. ASPR also works with national professional associations to identify and distribute resources to health care entities and to HCCs. Additionally, HPP has collaborated with the Federal Emergency Management Agency's (FEMA's) Center for Domestic Preparedness to develop trainings to support health care entities that are subject to the CMS emergency preparedness CoPs.

Other Federal Emergency Preparedness Activities That Impact HCCs

Other Federal agencies have emergency preparedness requirements or provide emergency preparedness funding that impact HCCs. Three key agencies are CMS, FEMA, and the Centers for Disease Control and Prevention (CDC). Additional Federal agencies impact HCCs, but to a lesser extent.

Centers for Medicare & Medicaid Services. In November 2016, new CMS regulations to include emergency preparedness requirements as CoPs for all Medicare- and Medicaid-reimbursed entities went into effect.[19] These entities include hospitals and 16 other types of health care entities.[20] Affected entities must have met all requirements 1 year after the effective date (i.e., by November 15, 2017). Specifically, these entities must now develop facility-based emergency programs that address how the facility would coordinate with other health care facilities—as well as the whole community—during an emergency or disaster. Depending on the type of services they provide, most of these entities must also train their staff in emergency preparedness principles and exercise their emergency plans in conjunction with other community groups. CMS's emergency preparedness CoPs require these entities to coordinate with emergency management agencies. The emergency preparedness CoPs also suggest that HCC membership may help these entities meet these new requirements.

On February 1, 2019, CMS added emerging infectious diseases to the current definition of an all-hazards approach. CMS determined that entities should consider preparedness and infection prevention within their all-hazards approach, which includes both natural and man-made disasters.[21]

Federal Emergency Management Agency. FEMA's Emergency Management Performance Grant Program and Homeland Security Grant Program fund State and local emergency management organizations. According to ASPR officials, the HPP and the Homeland Security Grant Program coordinate to ensure that their requirements include common language. The Homeland Security Grant Program allows (but does not require) emergency management organizations to work with HCCs to improve preparedness. Additionally, FEMA funds the Urban Area Security

Initiative. This grant program is one of three that make up the Homeland Security Grant Program. The Homeland Security Grant Program supports FEMA's core capabilities across the five mission areas of prevention, protection, mitigation, response, and recovery.[22]

Centers for Disease Control and Prevention. CDC monitors and responds to public health emergencies; conducts research; and provides guidance to health care providers, government entities, and the public.[23] CDC's Public Health Emergency Preparedness (PHEP) Cooperative Agreement supports the emergency preparedness efforts of State and local public health agencies. Since the 2012 project cycle, CDC and ASPR have aligned PHEP and HPP capabilities and established joint goals and activities to improve preparedness. For example, in response to the Ebola outbreak in 2014, CDC provided additional PHEP funding to States and localities;[24] stockpiled protective equipment for health care workers;[25] and revised its infection control guidance for health care providers, communities, and other public entities.[26]

Other Federal Agencies With Areas of Responsibility Related to HCCs. At least two other Federal agencies also have programs that affect HCCs and their members. These agencies include:

- The Health Resources and Services Administration (HRSA): HRSA's Emergency Medical Services for Children State Partnership Program provides funding to State governments and accredited schools of medicine. The funding supports demonstration projects to expand and improve State emergency medical services for children who need treatment for trauma or critical care.[27]
- The National Highway Traffic Safety Administration (NHTSA): NHTSA's Office of Emergency Medical Services coordinates the national emergency medical services system and co-coordinates the national 911 system through research and projects.[28] The Office of Emergency Medical Services is also part of a national focus on integrating emergency medical services into planning and preparedness initiatives.[29]

Related OIG Work

Several OIG reports have assessed health care entities' emergency preparedness and response efforts. These include hospital preparedness after the 2014 Ebola outbreak, nursing home preparedness and response during disasters from 2007-2010, and State and local preparedness for pandemic influenza in 2008. OIG work has resulted in requirements for better emergency planning and better coordination between health care providers. See Appendix B for more information on past OIG work.

Methodology

We selected a purposive sample of 20 HCCs from the total 476 HCCs at the time of our data collection. We also selected the 20 HPP awardees corresponding to these HCCs. These HCCs and HPP awardees all received funding as of the project cycle beginning July 2017. We conducted structured interviews, administered surveys, and collected documentation from each HCC and HPP awardee from November 2018 to January 2019. To ensure variation when selecting our sample, we selected at least 1 HCC from each of the 10 HHS regions and considered variations in population size and number of disasters recorded in the FEMA Disaster Database in 2017.

Through the interviews, we obtained qualitative data and organized the data on the basis of common themes. We also analyzed survey data and reviewed documentation, such as HCC membership lists, Cooperative Agreement requirements, and ASPR guidance (e.g., ASPR's Capabilities Document). See Appendix C for more details on our methodology.

This is not a review of the Federal, State, or local government response to the COVID-19 public health emergency.

Limitations

Because our sample of HCCs and HPP awardees is purposive, results apply only to the 20 HCCs and 20 HPP awardees in our review. Responses cannot be generalized to all HCCs or HPP awardees receiving HPP funds. Additionally, we selected the 20 HCCs on the basis of geographic distribution, size, and number of recent disasters. We did not consider other factors, such as how long each HCC had functioned as an HCC, when selecting our sample.

We requested supporting documentation that included membership lists. We did not independently verify the accuracy or completeness of this documentation. Additionally, we could not determine from the membership lists provided each HCC member's level of involvement with that HCC.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Nearly all 20 selected HCCs reported expanding their membership and that members participate in beneficial preparedness activities

Since ASPR's 2017 Cooperative Agreement requirements and CMS emergency preparedness CoPs went into effect, nearly all 20 HCCs in our review have expanded their membership to include new, more diverse entity types. Further, all selected HCCs reported that their members take part in HCC activities that benefit preparedness for a whole community emergency response.

Most of the 20 HCCs have expanded their membership, primarily through an increase in new diverse types of entities

Because of new ASPR 2017 Cooperative Agreement requirements and CMS emergency preparedness CoPs, 19 of the 20 HCCs in our review expanded their membership to include more types of entities than they had before 2017. The remaining HCC reported no expanded membership because it already had core and ancillary representation from all necessary community and health care entities before the HPP core member requirements became effective.

Six HCCs that expanded membership reported increases in one or more of the four types of core members (hospitals, public health agencies, emergency medical services, and emergency management organizations). Most HCCs already had core representation from these four entity types before the HPP required their membership. Further, our review of HCC membership lists confirmed that all 20 HCCs in our sample had representation from all four types of core members.

> Prior to this new guidance [to diversify membership beyond core members], we were specifically a hospital and Emergency Medical Services committee. Now, we have extended to home health, hospice, dialysis, long-term care, and community life programs.
>
> – HCC Representative

Of the HCCs in our review that reported expanded membership, all reported increases in ancillary members (e.g., home health agencies, long-term-care facilities). According to most (12 of 19) of these HCCs, this expansion was due to the CMS emergency preparedness CoPs. These requirements prompted entities that were subject to these CoPs to seek out membership in HCCs to help meet several of the CoPs. For example, HCCs reported offering training opportunities (9 HCCs) and community-based exercises, drills, or tabletop exercises (10 HCCs) as activities that helped entities to meet CMS emergency preparedness CoPs.

Our review of HCC membership lists showed that all 20 selected HCCs include ancillary members from diverse entity types. All but one HCC membership list included at least one type of ancillary member subject to CMS emergency preparedness CoPs. All HCC membership lists also included at least one other type of ancillary member not subject to CMS emergency preparedness CoPs. See Exhibit 3 for a list of the most

commonly reported types of ancillary members and Appendix D for a list of additional reported type of ancillary members.

Exhibit 3: HCCs reported a variety of ancillary member types on their membership lists

Ancillary members subject to CMS emergency preparedness CoPs	Number of HCCs reporting member type
Home health agencies	17
Long-term-care facilities	16
Outpatient clinics (e.g., clinics, rehabilitation agencies, and public health agencies as providers of outpatient physical therapy and speech-language pathology services or Comprehensive Outpatient Rehabilitation Facilities) *	14
Hospice	13
Federally Qualified Health Centers	11
Other ancillary members not subject to CMS emergency preparedness CoPs	
Fire departments	14
Assisted living facilities	11
Pediatric centers	11

Source: OIG analysis of membership lists for 20 selected HCCs, 2019.
* The membership lists that we analyzed did not designate which outpatient facilities were certified by CMS as Comprehensive Outpatient Rehabilitation Facilities. Because we could not distinguish Comprehensive Outpatient Rehabilitation Facilities from other types of outpatient clinics, we created a general category for outpatient clinics.

All HCCs reported that their members participate in beneficial preparedness activities offered by the HCC

Of the 20 HCCs in our review, all reported that both their new members and their experienced members participate in HCC-offered activities that benefit whole community preparedness. See Exhibit 4 on the next page for a list of the activities that HCCs reported.

Exhibit 4: HCCs reported a variety of beneficial preparedness activities in which their members participate

HCC preparedness activity	Number of HCCs reporting activity
Information sharing	11
Community-based exercises, drills, tabletops	10
Developmental activities (e.g., training and education)	9
Networking and relationship building	7
Resource sharing (e.g., staff and supplies)	4
Coordination	3
Situational awareness	2

Source: OIG analysis of HCC interview responses, 2019.

New ancillary members have benefited from participating in HCC activities with experienced core members. Specifically, more than half of the HCCs in our sample—11 of 20—reported that new ancillary members with previously limited experience are now learning about basic emergency concepts from experienced core members. For example, experienced core members helped ancillary members develop coordinated emergency-operations plans and exercise these plans.

Some of the new facilities have a lot of transportation and are willing to help evacuate when they are not themselves evacuating. The Surgery Centers have also offered up the use of their space if someone can get a generator there.

- HCC Representative

Experienced core members have also benefited from participating in HCC activities with new ancillary members. Specifically, 12 HCCs reported that increased coordination between new ancillary members and experienced core members helped their communities better prepare for and respond to an emergency. Seven of these HCCs reported that new ancillary members benefited their community preparedness by pointing out gaps in their respective health care systems' preparedness and response that experienced core members had not previously considered. Additionally, some HCCs (5 of 12) reported that new ancillary members provided new perspectives, expertise, and capabilities that benefited the HCC's core members. This included identifying and offering resources that the core members had not previously thought of or to which the HCC had not previously had access via its members. These resources include staff from private clinics and transportation from companies such as limousine services.

However, expanded membership also presents challenges. It has not always been done strategically and has caused some HCCs to concentrate limited resources on new members.

Although HCCs reported that expanded membership has benefits, they reported that this growth also presents challenges. The reported membership challenges appear to be from an influx of new ancillary member types resulting from HCCs expanding in ways that were not strategic. That is, most (18 of 19) HCCs reported accepting all entity requests to join their HCC without regard to the HCCs' identified community needs and health care system's gaps in preparedness and response. As a result, HCCs have many new ancillary members with significant training and education needs and little knowledge and experience in emergency preparedness. Therefore, more than half (12) of HCCs reported concentrating their limited resources on addressing these new members' needs. Some of these HCCs (4) reported that this concentration of limited resources on new member needs comes at the expense of other HCC priorities and goals.

HCC expansion is not always strategic

Most HCCs did not strategically determine which entities they should accept as ancillary members. Of the 19 HCCs that reported their membership is expanding, most (16) reported that they admit any entity requesting membership. Two additional HCCs specified that they admit as members any entity subject to CMS emergency preparedness CoPs. These 18 HCCs are not strategically growing their membership. Specifically, they do not prioritize new members based on their communities' health care systems' gaps in preparedness and response, as suggested by ASPR officials.

> We will accept any member. We welcome anyone who wants to be in the HCC and engage in preparedness.
>
> - HCC Representative

Eight HCCs indicated that they use assessments of their communities' health care systems' gaps in preparedness and response to help guide their membership, at least to some extent. Specifically, four HCCs reported that they use members' experiences with the health care system to assess gaps in their membership lists. However, only one of these four HCCs reported using identified gaps to prioritize HCC members. While the remaining three HCCs ensured that identified membership gaps were filled, they also allowed any other ancillary entity type requesting membership to become an HCC member. Of the remaining four, two HCCs reported using the Hazard Vulnerability Assessment and two HCCs reported using other formal assessments (i.e., public health needs assessment and gap analysis) to determine which entities were most important to include as members.[30] However, none of these HCCs used assessment-identified membership gaps to prioritize members and strategically grow their HCC. Instead, these four HCCs ensured that assessment-identified membership gaps were filled while also allowing any other ancillary entity type to become an HCC member.

Four others of the 19 HCCs that reported membership expansion reported that they implemented a committee structure as a strategy for integrating their new ancillary members into the HCC. Two of these four HCCs were among the five that use assessments to identify membership gaps. However, all four allowed any entity type to become a member and used a committee structure to integrate them into the HCC.[31]

Many HCCs concentrate their limited resources on the needs of new members

More than half (14) of the 20 HCCs in our sample reported that they spend a substantial part of their limited resources training new members to have the skills necessary to be contributing members. Additionally, six HCCs noted that frequent turnover at some ancillary member facilities means that training new, inexperienced members is a continuous and resource-intensive process. Nine HCCs reported that they have struggled to integrate new ancillary members and function as a unified HCC that focuses on the same goals. Three of these nine HCCs specifically reported concerns that the time dedicated to helping new members learn the basics of health care preparedness is changing the scope of their HCCs' work. Specifically, helping new members with their needs causes the HCC to focus less on planning for whole community emergency response coordination, continuity of health care service delivery, and medical surge than it did before its membership expanded.

> Because of the CMS rules, a lot of new people have come on board, but the facilities send new people who do not know anything about emergency preparedness. It takes a long time to get everyone to have the exercises they need to be compliant with CMS or other accreditation agencies.
>
> - HCC Representative

HCCs also reported spending considerable resources on activities to help members meet the CMS emergency preparedness CoPs. ASPR's 2017 Cooperative Agreement requirements do not allow HCCs to provide one-on-one support to HCC members to help them meet the CMS emergency preparedness CoPs, and no HCC in our sample reported violating this prohibition.[32] However, 18 of the 20 HCCs in our review reported using HPP resources to conduct group activities to help HCC members meet the CMS emergency preparedness CoPs. These activities include providing training to help members prepare for surveyor inspections and conducting entity-type specific exercises.

HCCs also face challenges in incentivizing core members' participation

While the CMS emergency preparedness CoPs have incentivized new ancillary member participation, most HCCs (18) expressed concerns about their ability to incentivize core members' participation in HCC activities. Despite some HCCs reporting benefits of expanding membership to diverse ancillary members, 7 of these 18 HCCs expressed general concerns that the HCC's focus on integrating new ancillary members has decreased the perceived value of the HCCs for some experienced core members. This perception has contributed to a decrease in core member participation in

some HCCs. Specifically, five of these seven HCCs reported that some of their core members are no longer participating in HCC activities or they participate less often than they once did.

HCCs most often reported specific challenges in incentivizing hospitals (12), followed by emergency medical services (11) and emergency management organizations (11). No HCCs in our review reported issues incentivizing the fourth core member type—public health agencies. The close association between CDC's PHEP Cooperative Agreement and the HPP likely facilitates public health participation in HCCs because HCC activities help public health organizations meet some PHEP requirements.

We have to accommodate the various levels of expertise and needs. Having the huge number of ancillary members come in has, frankly, changed the content enough that we are losing some of our core partners.

- HCC Representative

Challenges in incentivizing hospitals include competitor risk, competing priorities, HCCs' lack of hospital-focused content, and decreased financial compensation

For the 12 HCCs that cited challenges in incentivizing hospitals, 4 HCCs reported that hospitals are hesitant to participate fully in HCC activities with competitor hospitals. As one HCC explained, some hospitals feel that the risk of sharing their emergency plans with competitors is not worth the value they get from the HCC when the likelihood of an emergency response is low. Four HCCs explained hospitals' decreasing participation in the HCC stemmed from their perception that HCCs lack meaningful hospital-focused content. One of these four HCCs attributed this to the HCC's increased focus on the needs of ancillary members. Three of the twelve HCCs partly attributed the many other responsibilities that fall on hospitals for their waning participation. Further, three reported that the challenge was because hospitals are financially driven, and HCC participation can no longer result in direct financial assistance.

I have sensed a bit of a back stepping on the part of hospital leadership or the hospital emergency managers. They are not seeing the benefit to them.
- HCC Representative

Challenges in incentivizing emergency medical services include competing priorities and limited time and resources

Eleven HCCs reported challenges in incentivizing emergency medical services. Six of these eleven reported that the challenge stemmed not from a lack of a desire to participate in HCC activities, but from emergency medical services' inability to prioritize HCC activities given their other professional priorities. Two of these six HCCs reported that most emergency medical services in their State are volunteer organizations. Therefore, they have limited time or resources available for HCC activities. Four HCCs questioned the value that they could provide to emergency medical services. Five HCCs provided other reasons for challenges with emergency medical services, including the inability to compensate emergency medical services for their time and the misalignment of emergency medical services jurisdictional boundaries with HCC boundaries.

The biggest challenge is with emergency medical services. Most emergency medical technicians in our State are volunteers. It does not make sense for them to take time away from their paid job to attend a meeting for their volunteer job.

- HCC Representative

Some (5) of the eleven HCCs who reported challenges in incentivizing emergency medical services stated that they have strategized ways to better coordinate with emergency medical services other than asking them to participate in HCC activities. For example, three HCCs tried to enhance coordination with emergency medical services by sending HCC representatives to meetings that emergency medical services members already attended instead of asking them to come to separate HCC meetings. One of the HCCs that used this strategy reported some success in developing a strong line of communication between emergency medical services and the HCC.

Emergency management is a struggle because we need to make it about them, too. And sometimes, if it is too health-centric, they just do not show up.

- HCC Representative

Challenges in incentivizing emergency management organizations include competing priorities and perceived lack of HCC value

Eleven HCCs reported challenges in incentivizing emergency management organizations. Six HCCs reported that obtaining and maintaining participation from emergency management organizations was challenging given responsibilities associated with their full-time jobs and other emergency management duties outside of the HCC. Four others of these eleven HCCs stated that they were struggling to obtain and maintain participation because emergency management organizations did not appear to find value in HCC activities. HCCs reported that this is partly because emergency management organizations see HCC activities as focused solely on health care preparedness rather than general emergency management. One of these four HCCs reported challenges maintaining emergency management organization participation stemmed from the HCC's focus on ancillary members. This focus, the HCC explained, has resulted in a lack of content that is meaningful to emergency management organizations.

ASPR guidance is generally beneficial; however, some unclear 2017 Cooperative Agreement requirements and guidance contribute to HCC preparedness challenges

Overall, HCCs and HPP awardees generally found ASPR guidance useful in preparing for a whole community emergency response. However, HPP awardees interpreted membership requirements in different ways, indicating that HPP awardees find these requirements unclear. Further, based on our interviews with ASPR, HCCs, and HPP awardees, as well as our review of the 2017 Cooperative Agreement requirements and guidance, we found that some 2017 Cooperative Agreement requirements are not clear. Additionally, although ASPR described flexibility in cooperative agreement requirements, several HPP awardees reported challenges with other prescriptive requirements. This lack of clarity contributes to awardee challenges in guiding HCC strategic growth and in developing valuable HCCs that incentivize core members' participation.

HCCs and HPP awardees generally found ASPR guidance helpful

HCCs (19) and HPP awardees (15) found a variety of ASPR guidance helpful in preparing for a whole community response. The guidance they reported as helpful is listed in Exhibit 5 below.

Exhibit 5: HCCs and HPP awardees found a variety of ASPR guidance helpful in preparing for whole community response

Type of guidance	HCCs (n=20)	HPP Awardees (n=20)	Total (n=40)
ASPR Capabilities Document	18	14	32
ASPR TRACIE technical resources	16	14	30
ASPR webinars	14	12	26
Field Project Officers	9	13	22
ASPR TRACIE Assistance Center	14	5	19
HHS's 2009 *Medical Surge Capacity and Capability Manual*	11	7	18
ASPR TRACIE Information Exchange	10	7	17

Source: OIG analysis of data from survey of HCCs and HPP awardees, 2019.

Some 2017 Cooperative Agreement requirements and guidance regarding HCC membership are not clear, which contributes to HCCs' lack of strategic growth

Unclear 2017 Cooperative Agreement requirements and guidance contributed to some HPP awardees not directing their HCCs to use assessments, such as Hazard Vulnerability Assessments, to strategically grow. According to ASPR officials, HCCs should decide which entities to include as ancillary members based on assessments that identify jurisdictional health care systems' gaps in preparedness and response. However, neither the 2017 Cooperative Agreement requirements nor the guidance that we reviewed explicitly convey this expectation. This lack of clarity in the membership requirements and guidance contributed to HPP

awardees' different interpretations of how they should direct or guide their HCCs' membership growth. Only one HPP awardee in our review reported that it directed its HCCs to grow strategically using assessments of the health care system's gaps in preparedness and response.[33] The remaining HPP awardees reported no strategy for guiding HCC membership decisions (8 HPP awardees), leaving membership decisions up to experienced HCC members (7 HPP awardees), encouraging or allowing their HCCs to accept any entity that requests HCC membership, or any entity listed as a possible member in ASPR's Capabilities Document or HPP annual reporting guidance (3 HPP awardees); or not knowing how its HCCs determined membership (1 HPP awardee).[34]

> The whole world has to be invited to the HCC. I think ASPR is really getting too far down the road with how they are requiring so many organizations to be involved.
>
> - HPP Awardee

In addition, we found some potentially conflicting excerpts in the 2017 Cooperative Agreement and the ASPR Capabilities Document regarding HCC membership. These potentially conflicting excerpts likely contributed to HPP awardees' perception that ASPR does not recommend using assessments to guide strategic membership growth. For example:

- The 2017 Cooperative Agreement requirements state that HPP "awardees must ensure that there are no geographic gaps in HCC coverage and that all interested health care facilities, including independent facilities, are able to join an HCC, if desired." This excerpt implies that ALL health care entities should be HCC members.
- ASPR's Capabilities Document states that HCCs should "include enough members to ensure adequate resources" but that "having too many members may make the HCC unmanageable." This excerpt implies that NOT ALL health care facilities should be members of the HCC.

> Most HCCs have stuck to core four plus maybe some ancillary membership according to the broader medical system. HCC membership varies from region to region.
>
> - HPP Awardee

The 2019 Cooperative Agreement, effective July 2019, partially addresses this lack of clarity by removing the language stating that HCCs must ensure that all interested health care entities are able to join the HCC. However, it did not clarify that HCCs should prioritize member types on the basis of an assessment of the health care system's gaps in preparedness and response, as ASPR officials told us is recommended. See Appendix E for a table of 2017 Cooperative Agreement requirements and guidance excerpts from the 2017 Cooperative Agreement and ASPR's Capabilities Document about HCC membership that we found were unclear.

Unclear flexibility in the 2017 Cooperative Agreement requirements may contribute to HCC challenges in incentivizing core members' participation

There are a lot of "musts" in the Cooperative Agreement. If it is not a meaningful experience, or if members leave meetings saying, "well that was worthless," we are going to lose them.

- HPP Awardee

Some HPP awardees' perception that 2017 Cooperative Agreement requirements are prescriptive may lead them to manage, oversee, or guide HCCs in ways that meet 2017 Cooperative Agreement requirements but that do not create value for core members. HCC activities must offer enough value that core members are incentivized to participate, as one HPP awardee reported. However, more than half of the HPP awardees (14) in our review reported that prescriptive 2017 Cooperative Agreement requirements do not allow them to develop valuable HCCs. That is, the HPP awardees perceived that they could not support HCC activities that addressed unique priorities such as those identified as health care system preparedness or response gaps. Further, 8 of the 14 HPP awardees reported that prescriptive requirements force HCC members to work on activities that "check the box" but do not advance preparedness and response capability in their respective jurisdictions. For example, one HPP awardee reported that the work required for a very detailed budget plan used time that HCC members could have used on preparedness activities. Further, 4 of the 14 HPP awardees specified that prescriptive 2017 Cooperative Agreement requirements are currently causing core members to scale back their participation in HCC activities.

We had 7 years of building these HCCs, and now there are all these "musts" that the HCCs push back on. How are they going to keep doing things under restrictions? Do we sacrifice the usefulness of the coalitions to meet the requirements, so we keep getting money?

- HPP Awardee

Although most HPP awardees do not perceive flexibility in the 2017 Cooperative Agreement requirements, ASPR officials reported that there is some flexibility in how HCCs and HPP awardees may meet requirements. ASPR officials told us that if an HCC or HPP awardee believes that a requirement does not apply to the HCC's or the HPP awardee's unique situation, the HCC or HPP awardee can work with its Field Project Officer to negotiate alternatives that would be more responsive to its needs. However, this flexibility is not clearly stated in any of the 2017 Cooperative Agreement requirements or guidance documents that we reviewed.

CONCLUSION AND RECOMMENDATIONS

The selected HCCs in our review reported increased involvement in whole community preparedness following changes to certain facilities' preparedness activities requirements in 2017. However, they also reported developmental challenges that require continued focus.

Specifically, HCCs in our review reported that since 2017, they have expanded their membership, primarily through the addition of new ancillary members seeking to meet CMS's emergency preparedness CoPs. The HCCs also reported that new ancillary members and experienced core members now participate together in HCC activities that benefit whole community preparedness.

Although HCCs reported on the benefits of expanded membership, they also reported that this expansion presented challenges. For example, some HCCs reported having added new ancillary member types in ways that were not strategic. Specifically, many HCCs admitted all new entities that requested to join, regardless of whether the new members filled gaps in their communities' identified needs for health care system preparedness and response. Further, some HCCs reported concentrating their limited resources on conducting group activities to help new ancillary members meet the CMS emergency preparedness CoPs. These activities lessened the resources available for other HCC priorities.

Further, most HCCs also reported challenges in incentivizing core members' participation. In some cases, HCCs' challenges in incentivizing core members were related to the concentration of HCC's resources on new ancillary members to the detriment of other preparedness activities. Most HCCs also reported other challenges specific to incentivizing one or more of the four types of core members.

Finally, HCCs and HPP awardees generally found ASPR guidance helpful for preparing for a whole community response. However, some unclear 2017 Cooperative Agreement requirements and guidance regarding membership and lack of clarity about requirement flexibility contributes to the challenges that HCCs and their HPP awardees report.

We did not conduct a review of the Federal, state, or local government response to the COVID-19 public health emergency.

To further improve communities' preparedness for a whole community emergency response and ensure the benefits of membership expansion outweigh the challenges, ASPR should:

Clarify HPP guidance that HCCs' membership should ensure strategic, comprehensive coverage of their communities' gaps in preparedness and response

ASPR should consolidate the most pertinent guidance regarding HCC membership and clarify that only core members are required. Further, ASPR should clarify that HCCs should ensure that all other members represent entity types necessary for an effective whole community response. HCCs should determine which member types are necessary for an effective whole community response using assessments of the health care systems' gaps in preparedness and response (e.g., Hazard Vulnerability Assessments (HVAs)). This clarified ASPR guidance could also include how HCCs may use assessments to identify which entities are necessary for an effective whole community response. Additionally, ASPR should also emphasize existing ASPR guidance that HCCs may use an ancillary committee structure to integrate large groups of similar types of members.

Continue to work with CMS to help health care entities comply with the CMS emergency preparedness CoPs

ASPR should continue to work with CMS to provide health care entities with tools and resources that can help them comply with the CMS emergency preparedness CoPs. This would ensure that the burden does not fall solely on the HCC to provide basic emergency preparedness training to ancillary members. This would also allow the HCC to stay focused on whole community preparedness. Specifically, ASPR should continue to collaborate with CMS to compile lists of local or virtual training and consultation resources to help health care entities comply with the CMS emergency preparedness CoPs. HCCs can, in turn, help community health care entities by referring entities to these identified resources rather than providing the bulk of new member training themselves. Additionally, ASPR should continue to work with national professional associations to identify and distribute resources to health care entities that need help complying with the CMS emergency preparedness CoPs.

Identify ways to incentivize core member participation in HCCs

ASPR should work with HPP awardees to identify promising practices to incentivize core member participation in HCCs. One approach would be to make it easier for core members to participate. For example, ASPR could encourage HCC representatives to attend scheduled professional meetings held by core member groups instead of asking core members to attend a separate HCC meeting. Another option would be to make sure that HCCs provide value to all members, especially core members. Toward that end, ASPR could critically examine its reporting requirements to determine which

may result in HCC activities that are of less value for some core members, and ASPR could eliminate or revise those requirements.

Clarify to HPP awardees the flexibility available in meeting Cooperative Agreement requirements

ASPR should clarify flexibility in Cooperative Agreement requirements to avoid HPP awardees' perception of prescriptiveness. For example, ASPR should make HCCs and HPP awardees aware of the option to work with their Field Project Officer when HCCs or HPP awardees find that (1) a requirement does not apply to their HCCs or (2) fulfilling the requirement hinders the HCC's ability to work on issues identified as a priority in assessments.

AGENCY COMMENTS AND OIG RESPONSE

ASPR concurred with all four of our recommendations. In particular, for our first and fourth recommendations, ASPR stated that it may clarify future HPP or other guidance to HPP awardees. For our second recommendation, ASPR stated that it will continue to build and leverage ASPR's TRACIE collaboration with CMS regarding the emergency preparedness COPs and making resources available to HCCs. ASPR also stated that it will continue to work with HPP partners, including national professional associations, to provide information on the CMS emergency preparedness CoPs and HPP program and policy updates. Finally, in response to our third recommendation, ASPR stated that it will look into core membership trends, and leverage forums and meetings with awardees, HCCs, and other health care organizations to identify lessons learned regarding core member recruitment and participation incentives.

OIG appreciates ASPR's efforts to address this important issue. However, OIG urges ASPR to more strongly consider taking action to clarify guidance to HCCs that membership should ensure strategic, comprehensive coverage and to HPP awardees that they have flexibility in meeting Cooperative Agreement requirements. Clarified guidance will reinforce the need for HCCs to focus their limited resources on their communities' priorities rather than on helping certain members to meet CMS emergency preparedness COPs that may not create value for core members. With clarified guidance, HCCs can more efficiently and effectively improve their communities' emergency preparedness and response.

For the full text of ASPR's comments, see Appendix F.

APPENDIX A: Summary of ASPR's Capabilities Document and Corresponding Requirements From the 2017 Cooperative Agreement

Exhibit A-1: In its document *2017–2022 Health Care Preparedness and Response Capabilities* (referred to in this report as "ASPR's Capabilities Document"), ASPR has aligned aspirational capabilities for health care system readiness with the requirements from the 2017 Cooperative Agreement.

Aspirational Capabilities		Requirements from the 2017 Cooperative Agreement*	
1	Foundation for Health Care and Medical Readiness	Establish an HCC Identify HCC members Establish HCC governance Develop a preparedness plan Assess hazard vulnerabilities and risks Assess regional health care resources	Characterize populations at risk Ensure sustainability and HCC value Engage executives, clinicians, and community leaders Implement National Incident Management System
2	Health Care and Medical Response Coordination	Develop HCC response plan Coordinate public health and health care emergency information sharing	
3	Continuity of Health Care Service Delivery	Develop and implement continuity of operations plan Assess supply chain integrity Protect the health care workforce	
4	Medical Surge	Coordinate volunteers Conduct coalition surge test Develop and implement crisis care strategies and crisis standards of care Assess alternate care systems	Assess immediate bed availability Address specialty surge—pediatric care, chemical/radiation, burn and trauma, behavioral health, infectious disease

Source: CDC and ASPR. *2017-2022 Hospital Preparedness Program (HPP)—Public Health Emergency Preparedness (PHEP) Cooperative Agreement,* CDC-RFA-TP17-1701, 2017. Accessed at https://www.grants.gov/web/grants/search-grants.html?keywords=CDC-RFA-TP17-1701 on February 2, 2019 and *ASPR 2017-2022 Health Care Preparedness and Response Capabilities.* Accessed at https://www.phe.gov/Preparedness/planning/hpp/reports/Documents/2017-2022-healthcare-pr-capablities.pdf on August 20, 2019.

* The 2017 Cooperative Agreement requirements listed here are requirement *categories*, under which more requirements are specified.

APPENDIX B: Related OIG Work

Exhibit B-1: OIG has previous studies related to health care facility emergency preparedness

Title	Report Number	Date Issued
Hospitals Reported Improved Preparedness for Emerging Infectious Diseases After the Ebola Outbreak	OEI-06-15-00230	October 2018
This report found most U.S. hospitals reported that they were not prepared for the 2014 Ebola outbreak, but they have since acted to improve preparedness for emerging infectious diseases. Hospitals reported improved preparedness by 2017, although hospital administrators expressed concerns about sustaining preparedness over time. There is one unimplemented recommendation related to coordination among ASPR, CDC, and CMS regarding guidance and practical advice.		
Gaps Continue To Exist in Nursing Home Emergency Preparedness and Response During Disasters: 2007–2010	OEI-06-09-00270	April 2012
In this followup to the 2006 study above, OIG found that the gaps identified in 2006 still existed.[35] OIG recommended that CMS revise Federal regulations to include emergency preparedness requirements. CMS implemented this recommendation in the form of the CMS emergency preparedness CoPs.		
OIG Memorandum Report: Supplemental Information Regarding the Centers for Medicare & Medicaid Services' Emergency Preparedness Checklist for Health Care Facilities	OEI-06-09-00271	April 2012
This memorandum issued with the 2012 report above stated that CMS could improve its checklist for health care facilities to use during emergency preparedness planning, including possible collaboration with HCCs.		
State and Local Pandemic Influenza Preparedness: Medical Surge	OEI-02-08-00210	September 2009
This report found that hospitals could improve planning and coordination for medical surge during influenza pandemics. OIG recommended that, in collaboration with CDC, ASPR should continue to emphasize the importance of coordination involving a wide array of partners in medical surge and pandemic planning. In May 2009, ASPR implemented all OIG report recommendations and the U.S. Department of Health and Human Services developed a handbook—*Medical Surge Capacity and Capability: The Healthcare Coalition in Emergency Response and Recovery*—that guides the creation of HCCs that include key health care providers.		
Nursing Home Emergency Preparedness and Response During Recent Hurricanes	OEI-06-06-00020	August 2006
This study found that nursing homes in the Gulf States experienced problems during Hurricanes Ivan, Katrina, Rita, and Wilma because of lack of effective planning and failure to execute emergency plans properly, even though they complied with Federal interpretive guidelines for emergency preparedness. In response, CMS developed a checklist for nursing facilities to use for emergency preparedness planning.[36]		

APPENDIX C: Detailed Methodology

Sample Selection

To select a purposive sample of HCCs, we considered the HCCs' regional location, the HCCs' jurisdictional population, and whether the HCCs experienced a disaster in 2017 according to FEMA's Disaster Database. To do this, we first stratified the population of 476 HCCs that received HPP funding in the 2017–2019 project cycle by the 10 HHS regions. Then, we used the 2010 United States Decennial Census data to determine each HCC's jurisdictional population.[37] HCCs had jurisdictional populations ranging from 1,394 people to more than 16.8 million people and had between 0 and 4 FEMA-declared disasters.[38] We purposively selected 20 HCCs that varied in population and in number of disasters. There were two HCCs from each HHS region, and no State was represented more than once. After we started data collection, one HPP awardee informed us that the State's HCCs had consolidated. Therefore, we recategorized that HCC from having a small jurisdictional population to having a large one.

Exhibit C-1: The States from which we selected our sample of HCCs (which varied by population served and as to whether the selected HCCs experienced a FEMA-declared disaster in 2017)

	Small HCC Population	Large HCC Population
No FEMA-Declared Disasters in 2017	Utah Oregon West Virginia Connecticut	North Carolina Pennsylvania Illinois Arizona Minnesota Colorado
At Least One FEMA-Declared Disaster in 2017	California New Hampshire Oklahoma Idaho Nebraska	Florida Puerto Rico Texas Kansas New York

Source: OIG analysis of HHS regional boundaries, 2010 Census data, and 2017 FEMA-declared disasters.
Note: We used the median jurisdictional population of all 476 HCCs (i.e., 571,000 people) to characterize HCCs' jurisdictional populations as "small" or "large." No HCCs in our sample had a population equal to the median.

For each sampled HCC, we also selected its respective HPP awardee (i.e., the State or Territory that administers funding to the HCC). This method resulted in 20 HPP awardees (out of a total of 62 HPP awardees receiving HPP funds). HPP awardees in our sample administered HPP funding to a

total of 219 HCCs, with each HPP awardee overseeing from 4 to 57 HCCs according to the data available at the time of our sampling.

Data Collection

We conducted structured interviews, administered surveys, and collected documentation for the 20 HCCs and the 20 HPP awardees in our sample. We asked HPP awardees about their experiences regarding all the HCCs in their jurisdiction and not only about the HCCs in our sample. In our documentation collection, we gathered each of the 20 selected HCCs' most recent HVA and membership lists. We collected this data between November 2018 and January 2019.

During our interviews with the 20 HCCs and 20 HPP awardees, we asked respondents to describe strategies and experiences in engaging and coordinating with a diverse community and health care partners. We also asked respondents to describe any best practices, challenges, or concerns in adhering to 2017 Cooperative Agreement requirements and ASPR guidance. Finally, we asked respondents about the accessibility and usability of ASPR guidance and technical assistance when engaging, coordinating, and integrating diverse community and health care partners. We administered surveys to further determine what ASPR guidance HCCs and HPP awardees found helpful.

We also collected 2017 and 2019 Cooperative Agreement requirements and ASPR guidance, including the ASPR's Capabilities Document. Additionally, we interviewed ASPR staff to seek clarification and further understand both the goals of the HPP regarding whole community emergency response, as well as ASPR's oversight of HPP.

Data Analysis

To determine the extent to which HCCs and HPP awardees reported preparing a diverse group of core and ancillary members and to determine the challenges and benefits associated with this, we conducted qualitative data analysis on the interview responses from the 20 HCCs and 20 HPP awardees. Through several rounds of reviewing interview responses, we identified themes that were common among the interviews. We grouped these themes into common categories which we developed into findings. For the purposes of this study, we considered HCCs to have grown strategically if they prioritized membership on the basis of assessments of their respective health care systems' gaps in preparedness and response.

We also analyzed HCC membership lists for the 20 selected HCCs to help corroborate interview responses. HCCs presented their membership data in a variety of ways (e.g., a list of attendees at the most recent meeting, an Excel spreadsheet created in response to our inquiry) and may also

define members differently. We did not independently verify that these members fulfill the HPP membership requirements of an HCC member. That is, these members may or may not be entities within the HCC's defined boundaries that contribute to HCC strategic planning; identification of health care systems' gaps in preparedness and response and mitigation strategies for those gaps; operational planning and response; information sharing; and resource coordination and management.

To determine which ASPR guidance HCCs and HPP awardees found helpful, we analyzed interview and survey responses. Further, to identify potential misinterpretations of the guidance (i.e., misinterpretations of the 2017 and 2019 Cooperative Agreements and ASPR's Capabilities Document), we reviewed interview responses from HCCs and HPP awardees and compared them to the ASPR guidance and requirements from the 2017 Cooperative Agreement. Additionally, we analyzed these documents to determine instances of possibly unclear or conflicting language. We also reviewed responses from our interviews with ASPR staff to understand Cooperative Agreement requirements and ASPR guidance.

APPENDIX D: Additional Ancillary Member Types Included in HCC Membership Lists

Exhibit D-1: Number of HCC membership lists that reported at least one member of the additional ancillary member types

Ancillary members subject to CMS's emergency preparedness CoPs	Number of HCCs reporting member type
Community mental health centers	10
End-stage renal disease facilities	10
Ambulatory surgery centers	9
Intermediate Care Facilities for Individuals With Intellectual Disabilities	5
Psychiatric residential treatment facilities	5
Religious nonmedical health care institutions	3
Organ procurement organizations	1
Other ancillary members not subject to CMS's emergency preparedness CoPs	
Nongovernmental and volunteer organizations*	10
Other local, State, and/or Tribal government agencies	10
Academic or research institutions	8
Local health care professional organizations (e.g., hospital associations)	8
Public safety and law enforcement	7
Information management and infrastructure organizations	5
Non-health-care-related businesses (e.g., automotive networks or consultants)	5
Other health care facilities (e.g., alternative medicine facilities; clinical labs; trauma and burn centers; substance abuse facilities; pharmacies; and medical suppliers)	5
Schools	5
Cities, counties, parishes, townships, and Tribes	4

Social and human services	4
Other ancillary members not subject to CMS's emergency preparedness CoPs	**Number of HCCs reporting member type**
Housing and shelter services	3
Coroners	3
Blood banks	2
Dental offices	2
Poison control	2

* This category includes the American Red Cross and the Medical Reserve Corps (MRC). The MRC is an ASPR-sponsored network of community-based volunteers, initiated and established by local organizations to meet the public health needs of their communities.
Source: OIG analysis of membership lists for 20 selected HCCs, 2019.
Note: We reviewed membership lists to identify at least one member in each member type. An HCC may not be included in those reporting each member type for one or more of four reasons: (1) the HCC did not report the member type on its membership list because it mistakenly left a member off the list; (2) the HCC did not report the member type because no entities of that member type fall within the HCC's jurisdiction; (3) the HCC did not report the member type because entities of that member type fall within the HCC's jurisdiction but are not members; and/or (4) the HCC reported the member type on its membership list but did not provide sufficient information about the member for us to categorize it, and our independent research about the member did not reveal information that would allow us to categorize it. We did not determine the extent to which any of these four factors affected our analyses.

APPENDIX E: Excerpts of Unclear 2017 Cooperative Agreement Requirements and Guidance Regarding HCC Membership

Exhibit E-1: Two different HCC documents—the 2017 Cooperative Agreement and ASPR's Capabilities Document—provide information about membership and the expectations related to ancillary members that can be interpreted in different ways

Cooperative Agreement requirement or ASPR guidance excerpts suggesting that *all health care facilities and community entities should be HCC members*	**Cooperative Agreement requirement or ASPR guidance excerpts suggesting that HCCs should *use assessments to prioritize HCC members***
• HPP awardees must ensure that there are no geographic gaps in HCC coverage and that *all interested health care facilities*, including independent facilities, *are able to join an HCC*, if desired. (2017 Cooperative Agreement, p. 17) • The HCC *should liaise with the broader response community* on a regular basis…*Additional HCC members may include but are not limited* to the following: * o Behavioral health services and organizations o Community Emergency Response Team and Medical Reserve Corps o Dialysis centers and regional end-stage renal disease (ESRD) networks o Federal facilities o Home health agencies o Infrastructure companies o Jurisdictional partners o Local chapters of professional organizations o Local public safety agencies o Medical and device manufacturers and distributors o Non-governmental organizations o Outpatient health care delivery o Primary care providers o Schools, universities, and academic medical centers o Skilled nursing, nursing, and long-term-care facilities o Support service providers (e.g., clinical laboratories, pharmacies, radiology, blood banks, poison control centers) o Other (e.g., child care services, dental clinics, social work services, faith-based organizations) (ASPR's Capabilities Document, p. 11)	• HCCs must collaborate with a variety of stakeholders *to ensure the community has the necessary medical equipment and supplies, real-time information, communication systems, and trained and educated health care personnel to respond to an emergency*. These stakeholders include core HCC members and additional HCC members… HCCs should include a diverse *membership to ensure a successful whole community response*. (2017 Cooperative Agreement, p. 18) • The HCC and its members should use the information about these risks and needs (from HVAs) to … *prioritize strategies to close or mitigate preparedness and response gaps* within their boundaries. (2017 Cooperative Agreement, p. 22) • The HCC should Include *enough members to ensure adequate resources*; however, at the same time, having *too many members may make the HCC unmanageable* (ASPR's Capabilities Document, p. 11) • HCC members should perform an *assessment to identify the health care resources and services that are vital* for continuity of health care delivery during and after an emergency. (ASPR's Capabilities Document, p. 14)

Note: OIG italicized phrases above to add emphasis.
* In the interest of space, we removed some examples of facilities which appear in the original list of possible members.

APPENDIX F: Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of the Secretary

TO: Office of Inspector General, Department of Health and Human Services

FROM: Robert Kadlec, MD, MTM&H, MS
Assistant Secretary for Preparedness and Response

SUBJECT: OIG Draft Report: *Selected Health Care Coalitions Increased Involvement in Whole Community Preparedness But Face Developmental Challenges* – **INFORMATION**

The Department of Health and Human Services' (HHS) Office of the Assistant Secretary for Preparedness and Response (ASPR), appreciate the opportunity to review and comment on this draft report. The Office of Inspector General's (OIG) recommendations regarding the Hospital Preparedness Program (HPP) and the associated health care coalitions (HCC) and the Departments responses are discussed below.

OIG Recommendation 1:
Clarify HPP guidance that HCC membership should ensure strategic, comprehensive coverage of their communities' preparedness and response gaps.

HHS Response 1:
Concur. ASPR might look to address by clarifying in future HPP continuation guidance or other guidance to the HPP cooperative agreement recipients.

OIG Recommendation 2:
Continue to work with CMS to help health care entities comply with the CMS emergency preparedness Conditions of Participation (CoPs).

HHS Response 2:
Concur. ASPR will work to continue to build and leverage ASPR's Technical Resources, Assistance Center, and Information Exchange (TRACIE) collaboration with CMS regarding preparedness CoPs and make resources available to coalition; feature and promote ASPR TRACIE's dedicated resources for health care coalitions; and ASPR will continue to work with HPP's partner community, which is made up of national professional associations, to provide information on the CMS emergency preparedness rule and HPP programmatic and policy updates.

OIG Recommendation 3:
Identify ways to incentivize core member participation in HCCs.

HHS Response 3:
Concur. Initially ASPR will look to 1) a review of core membership participation data to identify core memberships trends over time and 2) leverage forums/meetings with recipients,

HCCs, and representative organizations to identify lessons learned regarding core membership recruitment and participation incentives.

OIG Recommendation 4:
Clarify to HPP awardees the flexibility available in meeting Cooperative Agreement requirements

HHS Response 4:
Concur. ASPR HPP may address by clarifying in future HPP continuation guidance or other guidance to the HPP cooperative agreement recipients.

3/23/2020

Robert Kadlec, MD, MTM&H, MS

Assistant Secretary for Preparedness and Response
Department of Health and Human Services

ACKNOWLEDGMENTS

Lauren Buss served as the team leader for this study, and Margaret Naughton served as the lead analyst. Others in the Office of Evaluation and Inspections who conducted the study include Taylor Eastman and Lori Jouty. Office of Evaluation and Inspections staff who provided support include Althea Hosein, Seta Hovagimian, and Christine Moritz.

This report was prepared under the direction of Dwayne Grant, Regional Inspector General for Evaluation and Inspections in the Atlanta regional office; Evan Godfrey, Deputy Regional Inspector General; and Jaime Stewart, Assistant Regional Inspector General.

To obtain additional information concerning this report or to obtain copies, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

ABOUT THE OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These audits help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

ENDNOTES

[1] Tampa Bay Health & Medical Preparedness Coalition, *Homeland Security Exercise and Evaluation Program (HSEEP) After Action Report/Improvement Plan: Hurricane Irma,* November 7, 2017.

[2] ASPR, *Hospital Preparedness Program: HPP Prepares the Nation's Health Care System To Save Lives During Emergencies and* Disasters. Accessed at https://www.phe.gov/Preparedness/planning/hpp/Documents/hpp-intro-508.pdf on May 13, 2019.

[3] The Coronavirus Aid, Relief and Economic Security Act (i.e., Cares Act) appropriated at least $250 million additional funds to the HPP. H. R. 748—275. Accessed at https://www.congress.gov/116/bills/hr748/BILLS-116hr748enr.pdf on April 21, 2020.

[4] The large metropolitan local governments include Chicago; Los Angeles County; New York City; and Washington, DC. The territories include American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands. The Freely Associated States include the Republic of Palau, the Federated States of Micronesia, and the Republic of the Marshall Islands.

[5] According to ASPR officials, ASPR assumed responsibility for the HPP's grants-management function from the Centers For Disease Control and Prevention's (CDC's) Office of Grants Services in 2018. As a result, ASPR canceled the remainder of the 2017–2022 project cycle and ASPR and CDC developed and published separate Funding Opportunity Announcements, effective in fiscal year 2019.

[6] ASPR, *Funding Opportunity Announcement and Grant Application Instructions Funding Opportunity Title: Hospital Preparedness Program Cooperative Agreement (CFDA # 93.889*), pp. 40–41. Accessed at https://www.grants.gov/web/grants/search-grants.html on March 19, 2019.

[7] ASPR, *Hospital Preparedness Program: HPP Prepares the Nation's Health Care System To Save Lives During Emergencies and* Disasters. Accessed at https://www.phe.gov/Preparedness/planning/hpp/Documents/hpp-intro-508.pdf on May 13, 2019.

[8] CDC and ASPR, *2017–2022 Hospital Preparedness Program (HPP)—Public Health Emergency Preparedness (PHEP) Cooperative Agreement*, CDC-RFA-TP17-1701, March 22, 2017. Accessed at https://www.grants.gov/web/grants/search-grants.html?keywords=CDC-RFA-TP17-1701 on February 2, 2019. Page 105 states that ASPR still permits funding from awardees to individual health care entities in Budget Period 1. However, "ASPR expects that as the project period progresses, the awardee's funding strategy will include allocating funding to HCCs in a graduated manner." In this way, HCC funding should have increased incrementally over the 5-year project period.

[9] Ibid.

[10] ASPR, *Funding Opportunity Announcement and Grant Application Instructions Funding Opportunity Title: Hospital Preparedness Program Cooperative Agreement (CFDA # 93.889*), p. 17. Accessed at https://www.grants.gov/web/grants/search-grants.html on March 19, 2019.

[11] According to ASPR officials, ASPR has most recently issued 5-year cooperative agreements for the HPP. The 2017 Cooperative Agreement includes Federal requirements, HPP program requirements, and HPP benchmarks that are applicable to HCCs and awardees. Additionally, according to ASPR officials, ASPR issues continuation guidance in years 2 through 5 of the cooperative agreement with more specificity on how to meet requirements.

[12] CDC and ASPR, *2017–2022 Hospital Preparedness Program (HPP)—Public Health Emergency Preparedness (PHEP) Cooperative Agreement*, CDC-RFA-TP17-1701, March 22, 2017. Accessed at https://www.grants.gov/web/grants/search-grants.html?keywords=CDC-RFA-TP17-1701 on February 2, 2019. Page 17 states that ASPR defines an HCC as a "coordinating body that incentivizes diverse and often competitive health care organizations and other community partners with differing priorities and objectives and reach to community members to work together to prepare for, respond to, and recover from emergencies and other incidents that impact the public's health."

[13] Revisions to the 2017 Cooperative Agreement included (1) clarifying the matching funds requirement, (2) changing the date for submission of health care system recovery plans, (3) adding a funding restriction on training courses, and (4) revising acceptable items to attach to applications for HPP funding.

[14] Federal Emergency Management Agency (FEMA), *Incident Command System Resources*, June 26, 2018. Accessed at https://www.fema.gov/incident-command-system-resources on July 30, 2019. The Incident Command System is a management system designed to enable effective and efficient domestic incident management by integrating a combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure.

[15] CDC and ASPR, *2017–2022 Hospital Preparedness Program (HPP)—Public Health Emergency Preparedness (PHEP) Cooperative Agreement*, CDC-RFA-TP17-1701, March 22, 2017. Accessed at https://www.grants.gov/web/grants/search-grants.html?keywords=CDC-RFA-TP17-1701 on February 2, 2019. Page 18 states that HCCs must include as members a minimum of two acute-care hospitals.

[16] Ibid. Page 18 states that emergency medical services include "inter-facility and other non-EMS patient transport systems."

[17] ASPR, *2017–2022 Health Care Preparedness and Response Capabilities*. Accessed at https://www.phe.gov/Preparedness/planning/hpp/reports/Documents/2017-2022-healthcare-pr-capablities.pdf on August 20, 2019.

[18] ASPR, *2017–2022 Health Care Preparedness and Response Capabilities*. Accessed at https://www.phe.gov/Preparedness/planning/hpp/reports/Documents/2017-2022-healthcare-pr-capablities.pdf on August 20, 2019. The capabilities are not requirements in the 2017 Cooperative Agreement, but rather high-level guidance for the preparedness of the Nation's health care delivery system, including HCCs and individual health care organizations.

[19] CMS, *Emergency Preparedness Rule*. Accessed at https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertemergprep/emergency-prep-rule.html on May 28, 2019.

[20] CMS, *Providers/Suppliers Facilities Impacted by the Emergency Preparedness Rule*. Accessed at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/17-Facility-Provider-Supplier-Types-Impacted.pdf on September 10, 2019. This CMS list treats critical access hospitals separately from other hospitals. For our purposes, however, we counted all hospital types, including critical access hospitals, as core HCC members.

[21] CMS, *Emergency Preparedness—Updates to Appendix Z of the State Operations Manual*, February 1, 2019. Accessed at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO19-06-ALL.pdf on March 5, 2020.

[22] FEMA, *Fiscal Year (FY) 2019 Homeland Security Grant Program (HSGP) Frequently Asked Questions (FAQs)*. Accessed at https://www.fema.gov/media-library-data/1555008515875-

3e335349f5d330de3f265af17c7e3409/FY19_HSGP_FAQ_FINAL_508.pdf on Novermber 21, 2019.

[23] CDC, *CDC: Mission, Role and Pledge*, April 14, 2014. Accessed at https://www.cdc.gov/about/organization/mission.htm on March 5, 2020.

[24] CDC, *2014 Ebola Response Supplemental Funding: PHEP Supplemental Funding for Ebola Preparedness and Response Activities*, April 18, 2017. Accessed at https://www.cdc.gov/phpr/readiness/funding-ebola.htm on March 5, 2020.

[25] CDC, *CDC Increasing Supply of Ebola-specific Personal Protective Equipment for U.S. Hospitals*. Accessed at https://www.cdc.gov/media/releases/2014/p1107-ebola-PPE.html on March 5, 2020.

[26] CDC, *Guidelines for Evaluation of US Patients Suspected of Having Ebola Virus Disease*, distributed via the CDC Health Alert Network on August 1, 2014. https://stacks.cdc.gov/view/cdc/24727 on March 12, 2020.

[27] HRSA, *Emergency Medical Services for Children State Partnership Program Funding Opportunity Number: HRSA-18-063*. 2018. Accessed at https://grants.hrsa.gov/2010/Web2External/Interface/Common/EHBDisplayAttachment.aspx?dm_rtc=16&dm_attid=37cb5412-fe0d-4eb6-83a7-189a5af748d0 on November 21, 2019.

[28] NHTSA, *EMS Improving Cardiac Arrest Response, CPR Training*. Accessed at https://www.nhtsa.gov/ems-improving-response-cardiac-arrests on November 21, 2019.

[29] NHTSA, *Preparedness: Fostering Collaboration Across the Federal Government to Enhance Readiness for Catastrophic Incidents*. Accessed at https://www.ems.gov/preparedness.html on November 21, 2019.

[30] All 20 HCCs in our review reported that they conduct Hazard Vulnerability Assessments (HVAs). However, only two reported using HVAs to inform membership decisions.

[31] Two of these four HCCs were among the five that use assessments.

[32] CDC and ASPR, *2017–2022 Hospital Preparedness Program (HPP)—Public Health Emergency Preparedness (PHEP) Cooperative Agreement*, CDC-RFA-TP17-1701, March 22, 2017. Accessed at https://www.grants.gov/web/grants/search-grants.html?keywords=CDC-RFA-TP17-1701 on February 2, 2019.

[33] We reviewed the data for the HCC corresponding to the awardee that reported directing its HCCs to use HVAs to determine gaps in membership. The HCC reported using member experience of the health care system to determine membership gaps.

[34] For the awardee in our review that did not know how its HCCs determined gaps in membership, we reviewed the data for the corresponding HCC in our review. This HCC stated that it does not use an assessment to determine which entities should become HCC members, but determines membership on the basis of the needs of its "key partners."

[35] OIG, *Gaps Continue to Exist in Nursing Home Emergency Preparedness and Response During Disasters: 2007-2010*, OEI-06-09-00270, April 2012. Accessed at https://www.oig.hhs.gov/oei/reports/oei-06-09-00270.asp on August 29, 2019.

[36] CMS, *Templates & Checklists*. Accessed at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Templates-checklists.html on May 22, 2018. CMS last revised this checklist in 2009.

[37] We used 2010 Census population data for all mainland HCCs and 2010 population data on local governmental websites for all territories and Freely Associated States. In the master list of HCCs that ASPR provided to us, it included the county/counties that each HCC served. We matched these counties to their 2010 population data using relationship files that were

accessed at https://www.census.gov/geo/maps-data/data/zcta_rel_download.html on June 13, 2018.

[38] While some HCCs did not appear as having any FEMA-declared disasters in 2017, we identified through interviews in some cases that an HCC may have responded to an emergency event that FEMA did not formally declare and was not captured in our sample selection methods.