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MEDICAL SURGE and the Role of ACCOUNTABLE CARE ORGANIZATIONS

ASPR
ASSISTANT SECRETARY FOR
PREPAREDNESS AND RESPONSE

TRACIE
HEALTHCARE EMERGENCY PREPAREDNESS
INFORMATION GATEWAY

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EXECUTIVE SUMMARY

Overview

Accountable care organizations (ACOs) are groups of healthcare providers and care settings that come together to deliver high-quality care to an assigned patient population. The Centers for Medicare & Medicaid Services (CMS) supports the development of ACOs through the Medicare Shared Savings Program and Innovation Center Models (e.g., the Next Generation ACO Model). Medicaid and commercial insurers have also established various ACO models for their beneficiary populations. ACOs provide incentives for groups of healthcare entities to coordinate care for their assigned patients with the goal of efficiently providing high quality care as measured by reduced inefficiencies and overall healthcare delivery costs. As a relatively new healthcare delivery and payment model, little is known about the role of Medicare ACOs and their participants in the medical surge response to emergencies and disasters.

The U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response (ASPR) Technical Resources, Assistance Center, and Information Exchange (TRACIE) conducted five telephone interviews with ACO leaders with beneficiaries in eight states to learn about their perceptions regarding the role of Medicare ACOs in supporting the health and medical response to disasters or emergencies. The interviews sought to assess Medicare ACOs and their participants': (1) role in emergency preparedness and response; (2) capacities and capabilities; (3) factors that challenge involvement; (4) factors that may facilitate engagement; and (5) lessons learned from real-life responses.

While ASPR TRACIE limited interviews to leaders of Medicare ACOs, it is expected that many of the findings and recommendations are also relevant to Medicaid and commercial insurance ACOs. Additionally, ASPR TRACIE observed that many of the insights shared about Medicare ACO participants were similar to those shared in extensive surveys and interviews with other [healthcare surge partners](#), suggesting commonalities in emergency preparedness and response capabilities, challenges, and experiences across non-hospital healthcare settings. Findings from this project will be used to increase awareness of ACOs and their participants' emergency capabilities and address some of their identified technical assistance needs.

Key Findings

Based on the interview data and environmental scan, ASPR TRACIE identified the following key findings:

- » There is wide variation in the composition of Medicare ACOs, including those comprised entirely of independent physician practices and various combinations of physician practices, hospitals, clinics, skilled nursing facilities, and other healthcare settings.
- » Due to their emphasis on healthcare quality initiatives, Medicare ACOs collect a great deal of data on their patients and have robust chronic care and other patient case management programs.
- » Interviewees recognized that emergencies and disasters have the potential to have significant and negative effects on beneficiary outcomes, the ability to meet quality measure reporting requirements*, and the financial health of participating practices. They also anticipated disruptions in continuity of patient care, particularly an increase in emergency department visits among those who are "anxious" as a result of the disaster or no longer able to maintain medications or other disease management activities.

**The Shared Savings Program makes adjustments to the ACO's performance year financial and quality performance when the ACO has been affected by extreme and uncontrollable circumstances. Details are available at: <https://www.federalregister.gov/documents/2017/12/26/2017-27920/medicare-program-medicare-shared-savings-program-extreme-and-uncontrollable-circumstances-policies>.*

- » Medicare ACOs may encounter important challenges to effective involvement in emergency response activities, including: loss of facilities/personnel; lack of adequately trained staff; focus on higher priorities or requirements; concerns about legal implications of providing care; and limited engagement with community emergency management partners and agencies.
- » Those interviewees already engaged in preparedness activities do so irrespective of their participation in an ACO. They tend to be in communities that have experienced recent disasters or are part of integrated healthcare systems with dedicated emergency management staff.
- » While the interviewees expressed the belief in the importance of emergency preparedness, they did not perceive it to be a priority for their ACO.

Though there are significant differences in the makeup, geographic areas served, and hazards faced by the Medicare ACOs associated with the interviewees, their insights suggest opportunities exist to support the readiness efforts of ACOs and their participants. ASPR TRACIE recommends this could be accomplished by:

- » Maximizing the data collection and analytics expertise of ACOs to identify the populations in a community most vulnerable during emergencies and disasters.
- » Leveraging existing technology such as telehealth and electronic medical records to maintain continuity of patient care for the ACO's beneficiary population.
- » Incorporating emergency management concepts in existing patient education and chronic care management programs.
- » Building communications networks to enable information sharing among ACO leadership, participants, and beneficiaries.
- » Developing checklists and other easy-to-use, customizable templates for ACOs to assess their readiness and support development of continuity of operations plans.

The interview findings are not intended to provide conclusive statements on emergency management that are generalizable to all ACOs and their participants. As an exploratory study, the interviews aimed to learn more about the current role of Medicare ACOs and their participants in emergency preparedness and response and to inform future efforts from ASPR TRACIE.

BACKGROUND

Medicare ACOs have been at the forefront of improving population health outcomes within the U.S. healthcare system since their inception through the Affordable Care Act in 2012. ACOs are defined by CMS as “groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to their Medicare patients.”¹ The largest ACO program within Medicare is the [Shared Savings Program](#). The Shared Savings Program is a key innovative program that leads the shift in CMS' payment system away from volume and toward value and improved patient outcomes.² It serves an alternative payment model that “promotes accountability for a patient population, and coordinates items and services for Medicare fee-for-service beneficiaries.”³ Medicare provider fee-for-service payments continue to be made in the same manner as they would be made otherwise, but at the end of each performance year, the ACO entity has an opportunity to share in a portion of the savings it generated for the Medicare Trust Fund when it meets quality and financial standards. A greater portion of shared savings are awarded to ACOs with higher performance on a set of quality measures including: patient/ caregiver experience, care coordination/ patient safety, preventive health, and at-risk population management.⁴

The Shared Savings Program has different tracks that allow ACOs to select a financial arrangement that makes the most sense for their organizations. ACOs must have an identifiable legal structure that is designed to provide a mechanism for shared governance for the ACO participants and to receive and distribute shared savings, if earned.⁵ In addition, ACOs are required to have a leadership and management structure in place that includes clinical and administrative systems. The ACO governing body and its leadership define processes that promote evidence-based medicine and patient engagement, for reporting on quality and cost measures, and for coordinating care.

A primary requirement for participation in the Shared Savings Program is that an ACO provides primary care services for at least 5,000 Medicare beneficiaries. Thus, ACO organizations differ widely with respect to both physician composition and the distribution of care provided by primary care physicians (PCPs) and other specialists. ACOs also vary in their size, leadership structure (physician-led or hospital-led), and service locations (urban or rural), all of which influence the physician composition and patient populations served.⁶

In response to the 2017 hurricanes and wildfire disasters, CMS established policies⁷ for assessing the quality and financial performance of Shared Savings Program ACOs affected by extreme and uncontrollable circumstances (e.g., Hurricanes Harvey, Irma, Maria, and the California wildfires, during Performance Year (2017) and to provide relief in subsequent performance years. Under this rule, Shared Savings Program ACOs are held harmless on quality performance standards when the ACO or more than 20 percent of its assigned beneficiaries are in a geographic area affected by extreme and uncontrollable circumstances.⁸ Additionally, CMS adjusts the calculation of shared losses for ACOs affected by extreme and uncontrollable circumstances.⁹ Aside from programmatic issues, ACO leaders have expressed challenges with having a basic understanding of how to interact with the response community, ensuring that their participating practices are prepared, and keeping populations healthy during disasters.

CMS's Center for Medicare & Medicaid Innovation tests other payment and service delivery models, including the Next Generation ACO Model.¹⁰ The [Next Generation ACO Model](#), which launched in 2016, is similar to the Shared Savings Program, but the participants assume higher levels of risk and reward. Under the Next Generation ACO Model, some Medicare fee-for-service rules are waived and other incentives are in place as benefit enhancements. Forty-one ACOs currently participate in the Next Generation ACO model.¹¹

Through their collaboration, participants in these various ACO models provide vital primary care services to millions of Medicare beneficiaries. These organizations maintain strong relationships with their patients, but little is known about their perceived or actual role in emergency preparedness and response. While ASPR TRACIE limited interviews to Medicare ACOs, the Medicaid program and commercial insurers also have ACO contracts. As of early 2018, Medicare, Medicaid, and commercial insurer ACOs covered about 10% of the nation's population and were present in all 50 states.¹² In total, more than 1,000 ACOs covered nearly 33 million beneficiaries.¹³

Understanding the perceptions and challenges facing ACOs with respect to emergency preparedness is imperative for proper planning and resource development to support continuity of healthcare services within communities they serve. ASPR TRACIE conducted interviews with leaders of Medicare ACOs to better understand the potential role of ACOs and their participants in support of the health and medical response to disasters or emergencies and possible barriers and obstacles to their participation. The key findings describe specific needs of ACOs relative to emergency management that ASPR TRACIE and other stakeholders may be able to address through future technical assistance efforts.

"ACO participants work collaboratively to achieve the triple aim of improving the experience of care, improving the health of populations, and reducing per capita costs of health care."¹⁴

METHODOLOGY

ASPR TRACIE conducted in-depth telephone interviews with leaders of select Medicare ACOs to better understand the perceived role, capabilities, and obstacles to emergency preparedness and response of ACOs and their participants.

The following questions were addressed in the interviews:

1. What is the role of Medicare ACOs and their participants in healthcare system emergency preparedness and response to medical surge incidents?
2. What capacities and capabilities do Medicare ACOs have to support emergency preparedness and response among their participants and beneficiaries?
3. What factors might pose an obstacle or challenge to the involvement of Medicare ACOs and their participants in emergency preparedness and response?
4. What factors can facilitate the involvement/ engagement of Medicare ACOs and their participants in emergency preparedness and response?
5. What lessons have Medicare ACOs and their participants learned from responses to real world emergencies or disasters?

A convenience sample of individuals serving in leadership positions of Medicare Shared Savings Program and Next Generation ACOs was identified through an existing relationship between CMS and ASPR TRACIE. ACO leadership positions included (but were not limited to) medical director, executive director, president, administrative officer, and board member. CMS identified six ACOs to invite to participate in an interview. This sample included Medicare ACOs that:

- Were primarily formed or led by small or solo physician practices.
- Ranged from those who have experienced an emergency or disaster to those who are disaster naïve.
- Represented both rural and urban areas as well as different geographic regions.
- Provided insights from the perspective of ACO leadership as well as ACO participants.

Five agreed to participate in interviews following receipt of recruitment emails and follow-up phone calls in May 2019. Interviewees did not receive an incentive for their participation.

CMS and ASPR TRACIE subject matter experts reviewed and provided extensive feedback to inform development and refinement of the interview guide prior to its use. ASPR TRACIE conducted telephone interviews May 7-17, 2019 with representatives of the five Medicare ACOs that consented to participate. The 30- to 40-minute interviews were intended to gain insights from the Medicare ACOs on the five key questions. Different interviewees received different questions based on their role relative to the ACO they represented. For instance, those serving in administrative roles for their ACO were asked about operational aspects of emergency preparedness and response across their ACO while ACO participants were asked about any effects of ACO participation on their healthcare setting or facility's emergency management activities. The interview guide is included as Appendix A.

ASPR TRACIE conducted qualitative analysis of the interview data. This included a review of interview recordings and notes to identify key insights and themes (repeated response patterns) that depicted participant perceptions. As appropriate, illustrative quotes are included throughout this report.

FINDINGS

Characteristics of the ACOs and their Participants

Interviewees represented five Medicare ACOs with participants caring for beneficiaries in eight states. All interviewees currently serve in an administrative capacity for their ACO. Three interviewees are also current participants in their ACO and a fourth is a former participant. None of those interviewed described emergency preparedness as their primary role within the ACO or as a participating provider.

Two of the five Medicare ACOs interviewed are composed solely of independent physician practices. One is primarily composed of independent physician practices, but also includes rural health clinics. Another is composed of a combination of hospitals and independent physician practices. The final Medicare ACO is composed of hospitals, skilled nursing facilities, home health, palliative care, paramedicine, and employed and independent physician practices.

Analysis of Findings by Key Theme

The following section is organized by key themes identified during the interviews with ACO leadership.

Role and Willingness to Participate in Emergency Preparedness and Response

ACOs strive to shift from volume-based to value-based care to improve the health of beneficiaries they serve. Medicare ACO leaders interviewed provided an in-depth understanding of how the coordinated care they provide fits into the larger healthcare delivery system, with strong emphasis and commitment to improving the health of populations across the country. This includes care for Medicare fee-for-service (FFS) beneficiaries not only prior to, but in the aftermath, of disasters or widespread emergencies.

- It all stems from achieving the triple aim, which is what we constantly think about, which is improving the patient's experience with medical care, improving the patient's outcome in care, and reducing overall expenditures. I think that falls into planning and deploying services for emergencies because this is where you get some of the more costly issues and the worst quality of care.
- From the ACO perspective, we believe that you have to be aligned – you don't necessarily have to be partnered and have contracts – but you have to be aligned with the healthcare system and all of the different facilities in the community because we touch them all. Whether it's the outpatient clinics or the hospitals or nursing homes, all of that, you've got to be able to work together.

Since ACOs manage large populations of Medicare FFS beneficiaries, the care they provide touches all aspects of the healthcare delivery system. ACO leaders reported building strong relationships with their beneficiaries. These leaders were asked to describe the perceived role their ACO and its participants would have during a response to a natural disaster or infectious disease outbreak. In general, interviewees viewed ACOs to have a role in proactive population health management of their assigned Medicare beneficiary population (with a strong emphasis on high risk and vulnerable patient management), infectious disease surveillance and early treatment, medication management, and patient outreach prior to a known natural disaster (e.g., hurricane). Additional information about specific capabilities is outlined in the next section.

Interviewees provided additional insight into their ACO's role in reducing and preventing emergency department overutilization. Several ACO leaders reported monitoring emergency department admissions of their assigned beneficiaries and proactively developing outreach and care plans to possibly prevent or reduce their beneficiaries' use of expensive acute care resources.

- Our job is—unless we have someone who actually needs to be seen—to work to keep everyone out of the hospital if possible.
- Last year when we had a really bad flu season, we found that our primary care providers in this ACO actually reduced emergency room visits in the face of a serious flu epidemic in the area because they had such good preventative care and procedures in their offices to see patients in a timely manner, and took care of patients in different ways using care management, so we saw how they were actually able to manage that population of patients very well during an epidemic type event.
- We continue to have...a partnership where any time one of our patients end up in an emergency room and the ER staff look that patient up to see what their insurance information is, if their Medicare number or any insurance number matches our list of beneficiaries we will then get a ping via a push notification and email that that patient is in the ER within 90 seconds. That gives us a little more understanding of where that patient is and also lets us know if the patient is admitted and when the patient's discharged from the hospital.
- Where we work on taking the pressure off the hospital system is that we'll do flu protocols so that if you're sick, you can call in and if you meet these check sheets we can give you fluids without coming into the office. We really push making sure that a patient is seen if they have a fever and we work on ensuring more sick people can be seen during the time they need to be seen. We're really looking at how to come up with other avenues of communication, whether it's telemedicine or it's virtual visits, and better triage so that the people with the flu have access and they're not going to the urgent care centers or the hospitals because otherwise we'll get to the point that we're on standby for every single hospital around us.
- We have quarterly meetings. We start focusing on hurricane preparedness a month or two before the season. You have to. Otherwise what happens is you'll watch the ER use and hospitalizations go up. You watch anxious people go up. You've gotta be prepared for the anxious people. You've got to have your cell phone. They have to know how to get a hold of you.
- All our high-risk patients are the first ones who get flu shots and that's how we tackled it at first. That's the primary level. The secondary level is providing same day appointments, same day access to care as much as possible, IV fluids in the office, volume antibiotics, whatever it takes to keep patients out of the emergency room. Following up with those patients—and right away if they did happen to go to the emergency room—helps make sure we prevent a second visit.

Although interviewees perceived emergency preparedness to be important, expressed willingness to contribute to disaster response, and identified roles they could play, none identified emergency management as a priority for their ACO. Interviewees represented ACOs with diverse participant compositions. Independent physician practice-operated ACOs demonstrated limited preparedness, although those who had experienced a real-life emergency had greater awareness of their gaps and sought to address them. Hospital and health system-led ACOs reported increased capabilities among their participants for emergency preparedness and response due to their operational nature, regulatory requirements (such as the CMS Emergency Preparedness Rule), and their defined role within their community's emergency response system. Leaders from these ACOs provided insight on their emergency preparedness efforts, but overall these efforts were not attributed to their participation within the ACO.

- The ACO has had very little involvement directly with emergency preparedness. As a hospital CEO, I can say we take emergency preparedness very seriously and have trained for several different emergency scenarios.
- Keep in mind, when there's a natural disaster, we're the only place with the lights on. If there's a power outage or something of that nature, we've got generator power to continue us going when everyone else is shut down. So, when something like this happens, we're the only things in town with the lights on, so, yes. We are prepared to handle a

medical surge. Our function as an ACO is completely unassociated with that aspect.

- We're very willing to work with governmental agencies and private agencies and organizations to try to improve healthcare in the United States when it comes to emergencies, but we do need resources – either resources in knowledge and experience or financial resources to help us get to those goals. Having those opportunities will certainly accelerate the buy-in for organizations because, again, even though this is a very important topic, people don't think about emergencies unfortunately until they happen. This is not the lowest hanging fruit for organizations such as ours and probably on an organic level would not be put in place for a very long time until everything else is in place.
- One thing you [a payer] may consider, and I'm not a proponent all the time for pushing mandatory types of things, but if emergency preparedness became something that everybody agreed is an important topic in the accountable care space, it could be put together as one of the quality metrics that is utilized to provide that shared savings reward. So if you have an emergency preparedness type of question that you could put into, let's say, your annual wellness visit or, as an example, with all of our annual wellness visits we currently get reimbursed \$50 to talk about advanced care planning, end of life care, which is very important.

Capabilities

Strong telehealth capabilities were reported by nearly all ACO leaders interviewed. These technology platforms allow ACOs and their participants to virtually interact with patients and maintain situational awareness and information sharing among ACO participants. Telehealth capabilities permit ACOs to conduct real-time online visits, provide mobile reminders, utilize remote patient monitoring devices, and record and save telemedicine interactions. While most interviewees only used telehealth during daily operations, all could envision using telehealth capabilities to provide critical messaging to their ACO participants and beneficiaries prior to, during (if IT services are not disrupted), and after disasters. The following statements demonstrate how telehealth capabilities are utilized by the ACOs interviewed:

- We are regularly communicating with our patients via text messaging and patient portal messaging. The text messaging is done in a secure manner through our EMR system.
- I think some of our interventions were probably a little more progressive. Then some of our peers followed suit after we offered free access, for example, to our telehealth services during the last hurricane.
- They implemented a telemedicine station from within the evacuation center that was staffed by emergency physicians from throughout our system to address acute needs and it was actually highly effective and cut the EMS calls down by at least 50 or 60%.

ACOs and their participants build strong relationships with their patient populations. As trusted providers, ACO leaders described strong capabilities in providing health education to their Medicare beneficiaries. Patient education occurs during in-office visits but also via telehealth systems. ACOs also have robust case management programs to coordinate care for patients with multiple co-morbidities or other complex conditions. Interviewees gave examples of how their ACOs conduct patient education and the potential for incorporating emergency preparedness messaging into their health education programs. As an example, ACO participants conduct "wellness calls" or patient check-up calls to high-risk and vulnerable individuals with chronic conditions (e.g., patients who need dialysis).

- We have an internal chronic care management program that connects our providers and patients and is used to educate patients on medical issues, but that can also be used to educate them on emergency preparedness so it's a great avenue to be able to deploy that. It's a great way to help because the patients now have that trust of their chronic care manager and they have that communication line open now so when the phone rings and they see that specific manager calling or that telephone number they're going to be more likely to answer.

- Most of our practices use patient education information all year round. Fliers and posters and brochures reminding them about proper use of primary care and emergency rooms and urgent care centers. This isn't something you can just implement for a one-time event. These are processes and education that the practices have been doing for some time and continue that messaging throughout the year.
- Calling ahead of a potential storm to check on medication refills, a significant enough supply of oxygen for the patient, making sure they've made arrangements if they have transportation issues. Where our clinics have care managers, we try to give their staff members some guidance on how to help prepare those higher risk patients.
- Our chronic care managers really stay on top of our highest risk patients. We typically take the top 10-15% of our patients that are the sickest of our population and try to manage them as much as we can with our chronic care managers so they can have a good relationship and good rapport with our patients and continue to educate those on a frequent basis.
- I think education and providing data would be a crucial role. Many patients, I think most patients, trust their medical providers, especially their primary care physicians to provide them with information. I think it's a great opportunity to be that point of contact in an emergency so long as the patient knows what to do.

When asked about emergency preparedness training and exercise capabilities, ACOs associated with health systems and hospitals reported being routinely involved in training and exercises for emergency preparedness and response coordinated by their facilities' emergency management staff to meet regulatory requirements. In contrast, independent physician practice ACO interviewees reported having little experience with emergency preparedness training and exercises. The following statements provide insight on their experiences with emergency preparedness training and exercises:

- I have not [participated in a drill] since my practice joined an ACO. As a resident we did drills in the hospital, which I think is actually very good and I think having more community participation would not be a bad thing.
- To the best of my knowledge, no, I don't think most of our physicians have the time or resources or sophistication to do that on their own.

ACOs have information on their known beneficiaries, but this information must be researched, collected, and analyzed by ACOs. They need to cross-reference CMS data of the names, Medicare identification numbers, and attributed providers of assigned beneficiaries with data – both demographic (e.g., address) and clinical – collected by each ACO participant to be able to identify beneficiaries more likely to be at risk during a disaster due to their location or condition. ACO participants often use various electronic health record systems that may not be interoperable, further complicating efforts to collect and analyze data. Leaders reported that collecting these data are extremely time consuming but having access to these data prior to a disaster would enhance the engagement of ACOs in emergency preparedness and response. These data would provide ACOs and their participants with an accurate glimpse of not only beneficiaries that have been seen by providers within the ACO but also those for whom the ACO is accountable but may not be engaged with the ACO at the time of the disaster.

- From the ACO's standpoint, we really use the ACO to transition from volume to value, how to improve the ongoing health of our patients. The thing that is of significant value is the data we receive – both as a biologic or immunization or infectious situation or a catastrophic natural disaster – the data we have helps determine who is the most vulnerable. For instance, if it were a natural disaster – earthquake, ice storm, something that shuts off power for a long period of time – we could use the data we receive from Medicare on our ACO patients to determine who's more vulnerable and likely to live alone.
- The ACO could have some tools if it had the ability to get that key information and what we need to know in an emergent situation regarding those beneficiaries. CMS data is very difficult to work with. It would help if they had it

packaged and ready to go when we have a pandemic or when we have a local crisis situation as what key things do we need to know about this group of 3,000 people or 20,000 people in our full ACO during this crisis.

- I think the first thing is the demographic information from governmental agencies like CMS. That could help us not have to spend a great deal of time and effort and energy collecting this internally and putting it together. We already have a data use agreement with CMS for data and I think that would be very helpful. In addition, I think a bidirectional flow of that data would be helpful for CMS as well. If CMS does not collect certain information such as telephone numbers or email addresses that ACOs have been hard at work trying to collect, that data might be very helpful to CMS to be able to better connect to patients.
- I've been involved in health information exchanges in the past so I know it was the dream to have some sort of locator, particularly when CMS knows which patients are attributed to which ACOs, but I'm not sure that it became reality in most places because it's so segmented.

Obstacles and Barriers to Preparedness and Response

Despite reporting a perceived role in providing education and outreach to patients, ACO leaders interviewed identified obstacles that may limit their ability to establish and maintain such communication during disasters. Daily patient outreach and education is supported by various communication platforms that allow for cell phone messaging, alerts, and calls but access to these systems was frequently reported as being compromised during disasters that impact community infrastructure. Based on their experiences during previous incidents, several interviewees reported obstacles with maintaining and accessing communication systems during disasters. These challenges extended to disruption in services that hinder their ability to send prescription orders to pharmacies to be filled in a timely fashion.

- It was not possible to use cell phones, it was not possible to use telephones for many days, and it was very difficult to access long stretches of road due to storm damage. It is challenging and sometimes you need to go to those very basic means of communication such as knowing a place where staff can meet up.
- Our entire communication system was down. All we knew was we had an older patient who lives alone. We don't know if they've evacuated and we have no way to get a hold of them. That's the kind of thing that really needs to be figured out. If I know that they live in a retirement community, I don't care. I know that retirement community is checking up on them. But the rural poor, that's the ones that aren't going to be checked on.

Lessons learned by ACO leaders during previous natural disasters clearly demonstrated how these incidents contribute to significant disruptions in the ability of ACO participants to maintain their operations. In general, ACO leaders expressed the importance of business continuity planning but also reported challenges to their ACOs and participants putting business continuity plans in place. Despite the contractual agreements between ACO participants, the leaders interviewed expressed mixed capabilities for providing continuity of care resources, such as staff and space, to other ACO participants impacted

If there is an emergency, the local emergency plan could open certain lines of communication for certain patients or make certain types of technology available to access that. For example, if there was some sort of specific telephone number or specific line of communication that could be accessed by not only the patient but also the providers, having that as a priority either to stay up or be put up when possible, that would be an important thing.

by natural disasters. Some interviewees shared experiences of supporting other participants by re-routing them to other participant providers and providing additional support if possible.

- Independent practice is kind of taking care of your own physical needs at the office. Making sure your own personal building is intact and usable. We all have our own independent practices that we need to maintain as well. Before we go out and start doing something for the good of humanity, we have to maintain our own patients and our own buildings and what not. Usually, most of us that are not affected go out and help.
- If we have a physician who just closes his or her doors, the chance of those patients having a more costly outcome is higher. Working together could reduce those costs and provide continuity and quality of care. We've been helpful in something like that so in a natural disaster, as an example, if someone's practice is either severely damaged or burnt down or whatever the case may be, we're able to divert potentially those patients to local practices to be able to help serve the need or have all the physicians meet at a central point to help triage patients. All those things are possibilities with this type of network.
- Because we're all in it together, it goes back to money or reimbursement as a reward or penalty. We've had instances of practices, for example, where something happened to the physician's family or hardship or whatever it might be and they've been forced to take a leave of absence or change and so forth and we've been helpful in going into our network of physicians that are regional and reaching out to see if any of our physicians could take some of the burden or load off that particular physician and that's happened to us on several occasions with success.
- We wouldn't have direct oversight over our acute facilities in terms of moving patients. However, if we identify patients at risk on the periphery of our acute care centers we could certainly influence decision making. It wasn't something we did for the ACO necessarily but more so from our network affiliation, the hospital management arm of the system, that they were managing that pretty tightly.
- Our communications efforts with staff is obviously whatever staff members can come in in an event like that—we could use their assistance as much as possible.
- The ACO as far as an organization has a plan just as far as when the disasters start getting, if we get close to a hurricane, this is when we start staying home. As an organization, we have a hurricane plan. Infectious disease wise we don't have anything. It's never been a big enough issue from an organizational point of view.

Interviewees also consistently reported lack of time to effectively participate in emergency preparedness activities for the entire ACO. This was commonly reported by ACO leaders from independent practice-led ACOs. These leaders reported having multiple roles within the ACO and within their own private practices making it extremely difficult to allocate time to emergency preparedness and planning with various competing priorities. In addition, independent practice ACO leaders were generally not familiar with nor required to comply with federal regulations for emergency preparedness such as the CMS Emergency Preparedness Rule as are many of their counterparts from large health systems and hospitals.

- For a community-based organization that doesn't get support from large systems, it's still very challenging to go to that level. We still have so many other things we have to accomplish to just survive in these changes. Though we'd love to do everything, at this point we haven't deployed other than in the chronic care management program and the push notifications to our physicians by email, which still isn't being opened by a large percentage of our physicians or staff. We've not really gone to the point of putting in policies or procedures for natural disasters or putting anything in place that we could use systemwide.
- In terms of the lowest hanging fruit for an organization such as ours, it [emergency preparedness] wasn't the first thing we were thinking about.

- It's always hard to implement guidelines to individual practices across a wide variety of people that have different viewpoints of different things. I guess a disaster management phone number program that we could call to get some assistance and guidance to the right resources, guide our patients to the right resources, would probably be the one thing that would be beneficial in that time period. Someone who knows where all the resources are.

Interviewees revealed an overall sense of uncertainty related to legal and financial issues that could result from their emergency preparedness and response efforts. In addition, many ACO participants are not engaged in the overall healthcare system response structure, resulting in numerous concerns surrounding scope of practice and crisis standards of care, such as what kind of patients can be seen at ACO participant sites during disasters. Concerns about legal obstacles may limit engagement of ACOs in community response planning.

From a financial standpoint, interviewees expressed concern related to uncertainty for how the disaster could impact the ACO and ACO participant practices. Disruption to services at ACO participant sites could potentially skew the cost of care (e.g., unanticipated increases or decreases) for beneficiaries who may seek an increased number of services outside of the ACO's geographic region or from non-ACO practitioners and sites, depending on how long services are disrupted and the ability of a practice to quickly recover after a disaster. Interview participants also expressed having a limited understanding of disaster funding opportunities.

- One of the reasons we're not going to be invited to community preparedness activities is because of the liability issues. I can't go out and see someone who's not a patient. So, it's not necessarily not wanting to participate when really, it's an issue of could we participate. I'll tell you, my entire group would close down the office and go help anywhere, but we're not really encouraged to do that.
- So, one of the things we did is called over to the major hospital and said send minor injuries over to us. We won't take any costs and we'll triage what we can and we'll eat the cost of whatever and we'll take care of it, but that wasn't done at an organizational level and had it been done that way it would have been better. Then the question becomes from a liability point of view, if somebody does that are they liable? We want to do something good but we don't want to be sued at the end of it.
- Other than waiting for the hurricane to start, we start doing reviews of the offices and we started doing newsletters before the storm, saying 'start thinking about it'. One of the things we realized was that practices needed to be able to float a line of credit and think about whether they are able to do this in case of a disaster from a financial standpoint.

ACOs participants are autonomous entities with individualized policies and procedures. During the interviews, ACO leaders provided insight on the challenges of streamlining procedures, and communication between the ACO and its participants. One major challenge noted was the lack of consistency between telehealth platforms, electronic medical records, and other IT systems. ACOs reported participants having disparate systems without interoperable capabilities. Differences between systems allow for complexity and obstacles in consistent messaging among ACO participants, situational awareness, standardizing communication, and outreach and education protocols. In addition, geographic variance among ACO participants was also highlighted during the interviews. ACOs participant locations vary greatly within ACOs, with participants located in metropolitan and rural areas, and often across state lines. These geographic differences add layers of complexity to the standardization of procedures, ACO-level risk identification and mitigation, and effective communication protocols.

- We could do better to ensure that the right group is meeting first. Then communicate a similar message for the impacted regions to ensure a consistent message about practice closures and emergency preparedness for the event.
- What we're trying to do in our organization is have a central opportunity to educate our physicians where everyone—no matter what type of EHR or communications system they have—can always receive information.

- I think that what we struggle with—in day to day operations as well as emergency preparedness—is what is the most effective communication that could go out as consistently and systemically as possible to the majority? It's really trying to identify what is our current state today to support that and what is our ideal state so we can work toward that. We're fortunate that all of our entities use the same software so when it comes to clinical information we can share it that way, but that's not really the platform for emergency preparedness. If we have clinicians in a clinical workflow EMR, they're not in Outlook, they're not in their email, they may not be accessible via the phone... we can't just push the alarm button and it goes to everyone all of a sudden like if you were in one geographic space.
- How do we look across the spectrum at all of it and make contacts to find out where people are? That kind of communication is key and I don't think it's done enough of so people look at silos so you have your office and you have your silo and then maybe somebody looks at as, ok, we've got our organization, we're just going to hunker down with our organization, and disaster preparedness is not across all organizations which is one of the big faults that I see.

RECOMMENDATIONS

Interviewees provided valuable insights about the perceived roles, barriers, and capacity of Medicare ACOs in emergency management. While there were significant differences in the ACO compositions among the ACO leaders interviewed, the insights by interview participants suggest that opportunities exist to engage and improve the readiness of ACOs and their participants. ASPR TRACIE recommends that this could be accomplished by the following:

- **Increase Awareness of the Role Accountable Care Organizations and their Participants Can Play in Community Disaster Response.** The perceived role of ACOs varied among the interview participants. It is evident from the various capabilities ACOs described during the interviews that ACO participants can support response activities within the communities they serve. With ACO leaders reporting strong capabilities to manage high-risk patients, provide patient education, and reduce the demand on local emergency departments it is imperative that other response agencies such as local emergency management and healthcare coalitions are familiar with the support ACOs can provide. The role ACOs can play in community response will vary depending on the composition of the ACO, since some ACO participants are actively engaged in emergency preparedness planning due to regulatory requirements or their potential association with a large healthcare system. Emergency management agencies and other healthcare partners can work with ACOs and their participants to identify a role ACO participants may have in supporting local community response efforts.
- **Increase ACO Leadership Investment in Business Continuity Planning.** Interview findings suggest a need for ACOs and their ACO participants to invest in business continuity planning. Lessons learned from previous natural disasters and infectious disease outbreaks demonstrated widespread disruptions to vital services provided by ACO participants. ACO investment in business continuity planning may minimize the effects of disruptions caused by disasters through quickly identifying crisis situations and understanding the vulnerabilities at the ACO administration level and within individual ACO participant sites. In addition, business continuity planning would support ACOs in identifying essential services, promoting pre-planning participant support activities such as the orderly referral of patients to alternate sources of care, and potentially reducing disaster-related financial loss. This investment may also enhance confidence among beneficiaries by knowing they can depend on providers within ACOs during emergency situations.
- **Explore the Feasibility of Including Emergency Preparedness in Payer Incentives.** The collaborative function of ACOs provides a unique opportunity to promote emergency preparedness among patients. Additionally, ACOs already have well-developed patient education and case management programs in which basic emergency preparedness concepts may be incorporated. Payers could explore incentives for the incorporation of emergency preparedness in

case management programs and patient education to enhance the relationships between ACO participants and their beneficiaries, while also building a culture of preparedness among staff and beneficiaries.

- **Develop Checklists and Tools to Enhance Knowledge and Capacity in Emergency Management among ACOs and their Participants.** Interview results suggest that ACO leaders understand the value of emergency preparedness planning but due to time constraints and competing priorities it is not always feasible. The findings also suggest a need to develop tailored checklists, factsheets, and resources for ACOs and their participants with differing levels of knowledge and capacity. This should include participant-based and ACO-based hazard and risk identification and mitigation strategies, emergency preparedness awareness messaging, general preparedness and response checklists, communications protocols, and general information on population health platforms such as emPOWER, and the Centers for Disease Control and Prevention's Social Vulnerability Index .
- **Continue to Promote Telehealth Capabilities within ACOs and their Participants.** Overall, ACO leaders interviewed expressed strong telehealth and telemedicine capabilities, and provided examples of how they utilize these capabilities to provide services to their beneficiaries. These systems can support information sharing between ACO leadership and participants while also establishing and maintaining communication with their beneficiaries during disasters or emergency situations.
- **Maximize the Data Collection and Analytics Expertise that are Hallmarks of Successful ACOs.** Many Medicare ACOs have robust data analytics capabilities that they use in daily operations to coordinate patient care and efficiently manage their resources. While none of those interviewed have used these capabilities during a disaster and several identified limitations in currently collected data, many envisioned analytics on the data collected on their own patient populations combined with other data sources as an untapped potential to identify the most vulnerable populations during a disaster and to collaborate with community partners to address their needs.

LIMITATIONS

The findings of this project are subject to several limitations. First, the small sample size is not representative of all Medicare ACOs or ACOs in general. Second, the project used a convenience sample identified by CMS staff. Third, no incentive was provided to encourage participation. Due to these limitations, the findings of this effort are not generalizable to all ACOs and it is not possible to make conclusive statements about the role of ACOs in emergency management. However, these findings do provide useful information to better understand the potential role of and obstacles to involvement in emergency management activities by ACOs.

CONCLUSION

Unless they were part of an integrated healthcare system or experienced a real-life emergency, Medicare ACOs interviewed by ASPR TRACIE have had limited engagement in emergency preparedness and response activities in their communities. Yet, interviewees identified capabilities – particularly in telehealth, case management, patient and provider education, and data analytics – that could be valuable to the overall medical surge response during an emergency. Healthcare coalitions and other community preparedness and response partners should be aware of this potential and explore increased engagement, including through the emergency management staff of hospitals and other integrated health system settings that participate in ACOs.

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APPENDIX A: INTERVIEW GUIDE

Discussion of Purpose and Review of Informed Consent

Thank you for agreeing to speak with me today. My name is [insert name]. I'm conducting this interview on behalf of the Office of the Assistant Secretary for Preparedness and Response (ASPR) Technical Resources, Assistance Center, and Information Exchange (TRACIE), which I may refer to as ASPR TRACIE. I work for ICF, a contractor supporting ASPR's TRACIE project.

Purpose and Procedures

ASPR TRACIE is conducting this project to improve understanding of the role of Medicare accountable care organizations (ACOs) in supporting the health and medical response to disasters or emergencies. You are among several ACO leaders we will be interviewing. Our discussion should take 30 minutes.

Voluntary Participation

Your participation in this discussion is completely voluntary. You do not have to answer any question that you do not want to answer. You may choose not to participate or to leave the discussion at any time. We will record the discussion and my colleague [first name] is on the line to take notes.

Privacy

The digital recording and notes of the interview will be stored in a password-protected folder. The recording will be destroyed when the project is over. Only members of the project team will have access to the notes and recordings, and they will not be allowed to share them with anyone else. Your name and organization name will not be used in any documents written on the basis of this project. Data will be presented in aggregate so responses will not be attributed to individual participants or the organizations with which they are affiliated. A final report will be posted on the ASPR TRACIE website. The findings may also be submitted for publication in a peer-reviewed journal. If you have any questions about this project, you can reach out to askasprtracie@hhs.gov.

Do you agree to participate in the interview? [Terminate interview if they do not verbally agree]

All Interviewees

I'd like to start by better understanding the ACO you are affiliated with and your role.

1. Please describe the composition of your ACO.
2. What is your role within your ACO?
 - How involved are you in emergency preparedness for your ACO?

Throughout the interview, please keep the following scenarios in mind:

An infectious disease outbreak is affecting your entire geographic region. Over an extended period of time, the number of infections will gradually increase, reach a peak, and begin to decrease. There will be high demands on the overall healthcare system. There may be high demand and low availability of healthcare personnel, supplies, and other resources.

A natural disaster such as a hurricane or wildfire occurs in your community and results in large numbers of injuries with limited or no warning. The healthcare system will absorb an immediate influx of patients with injuries of varying severity on top of its existing load of patients with chronic and acute illnesses and injuries. There may be infrastructure damage, security requirements, or communications breakdowns that challenge your response to the incident for an unpredictable amount of time due to electrical outages, telecommunications and IT system failure, supply chain disruptions, unnavigable transportation systems, and reduced staffing availability.

If the interviewee indicates in question 2 that he/she has a leadership role within the ACO but does NOT provide services as an ACO participant, ask the following:

3. How many participants do you have in your ACO?
4. In what state or territory is your ACO located (*This is the physical location of your ACO, this may be different than the regional service area in which your ACO provides services*)?
5. In what state(s) or territory(ies) do your ACO participants provide services?
6. Do you feel your ACO and its ACO participants would have a role in addressing healthcare needs in your community caused by either an infectious disease outbreak or natural disaster?
 - What do you think that role would be?
 - *If participant indicated their ACO would contribute differently depending on the different scenarios, ask for explanation.*
7. Has your ACO assisted its participants in responding to an emergency or disaster?
 - What type of real-life emergency impacted your ACO and its participants?
 - Do you have any lessons learned from that experience that you can share with me?
 - Can you describe the impact the real-life emergency had on your ACO's ability to ensure continuity of care for your patient population?
8. Do you know how to reach your region's healthcare coalition?
 - If yes, has your ACO engaged in any of the healthcare coalition's activities?
9. Are any of your ACO participants subject to the Centers for Medicare & Medicaid Services (CMS) Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers Final Rule?
 - Are you aware of any challenges your ACO participants have encountered in meeting those requirements? If yes, what were they? Did your ACO help them overcome those challenges? How?
 - Has being part of an ACO made it easier for any of your ACO participants to meet their CMS Final Rule requirements? Please explain.
10. Describe any resources or written procedures your ACO has to ensure effective operations during an emergency. For example, during a disaster or emergency does your ACO have plans or procedures to share personnel/staff and resources to support care coordination and continuity of patient care?
11. Describe your ACO's procedures for communicating with its ACO participants in advance of, during, and following an emergency.

12. Does your ACO have a business continuity plan in place?
 - If yes, please describe some of its key elements.
 - Have you activated the plan during either a real-life emergency or a drill or exercise?
13. What kind of emergency preparedness training is available across your ACO, if any?
14. Have any preparedness exercises been conducted that involve the entire ACO? If so, what types?
15. What factors might pose an obstacle or challenge to your ACO's involvement in an emergency response?
 - Can you explain why that might be a barrier for your ACO's involvement?
16. If your ACO were to incorporate additional emergency preparedness activities into your operations do you think these activities would improve the ACO's beneficiary experience?
17. What would make it easier for you to improve emergency preparedness across your ACO?
18. Has your ACO developed any emergency preparedness policies, procedures, or other resources that you would be willing to share through ASPR TRACIE with other ACOs?

If the interviewee indicates in question 2 that he/she is **ONLY** involved in the ACO as a participant, ask the following:

3. Please describe your healthcare setting (e.g., hospital, physician practice, clinic, etc.).
4. In what state(s) or territory(ies) do you provide services?
5. Do you feel you/your practice/your facility would have a role in addressing healthcare needs in your community caused by either an infectious disease outbreak or natural disaster?
 - What do you think that role would be?
 - *If participant indicated they would contribute differently depending on the different scenarios, ask for explanation.*
6. Has an infectious disease outbreak or natural disaster occurred in your area that affected your operations?
 - If so, please describe.
 - Did your [office/clinic/hospital] respond to the incident? If yes, how did you participate?
 - How did you maintain communications with your staff?
 - Can you describe any support you received from your ACO or your fellow ACO participants?
 - Do you have any lessons learned from that experience that you can share with me?
 - Did you make any changes to your policies, procedures, or protocols based on that experience?
7. Do you know how to reach your region's healthcare coalition?
 - If yes, has your practice/hospital/clinic engaged in any of the healthcare coalition's activities?
8. Is the facility or practice in which you work subject to the Centers for Medicare & Medicaid Services (CMS) Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers Final Rule?

- What challenges, if any, has your facility encountered in meeting those requirements? How has your facility overcome those challenges?
 - Has being part of an ACO made it easier for you to meet the CMS Emergency Preparedness Requirements? Please explain.
9. What policies, processes, or procedures are you aware of that would allow you and other ACO participants to support care coordination and continuity of patient care through an emergency or disaster?
 10. How would you notify your ACO leadership or other ACO participants if an emergency overwhelmed you or your practice's ability to continue to provide healthcare services?
 11. How would you modify your physical space and manage your resources to handle a large influx of patients above normal operating conditions?
 12. What factors might pose an obstacle or challenge to your involvement in an emergency response? Can you explain why that might be a barrier for your involvement?
 13. If you incorporated additional emergency preparedness activities into your operations do you think these activities would improve the ACO's beneficiary experience?
 14. What would make it easier for you to improve your emergency preparedness?
 15. Have you developed any emergency preparedness policies, procedures, or other resources that you would be willing to share through ASPR TRACIE with other ACO participants?

If the interviewee indicates in question 2 that he/she is BOTH an ACO participant and has a leadership role within the ACO, ask the following:

3. How many participants do you have in your ACO?
4. In what state or territory is your ACO located *(This is the physical location of your ACO, this may be different than the regional service area in which your ACO provides services)?*
5. In what state(s) or territory(ies) do you and other ACO participants provide services?
6. Please describe your healthcare setting (e.g., hospital, physician practice, clinic, etc.).
7. Do you feel your ACO and/or you and other ACO participants would have a role in addressing healthcare needs in your community caused by either an infectious disease outbreak or natural disaster?
 - What do you think that role would be?
 - If participant indicated they or their ACO would contribute differently depending on the different scenarios, ask for explanation.
 - How would you modify your physical space and manage your resources to handle a large influx of patients above normal operating conditions?
8. **A.** Has an infectious disease outbreak or natural disaster occurred in your area that affected your operations?
 - If so, please describe.
 - Did your [office/clinic/hospital] participate in the response? If yes, how did you participate?

- How did you maintain communications with your staff?
- B.** Has your ACO assisted your facility or other ACO participants in responding to an emergency or disaster?
- Can you describe any support provided by your ACO or you and your fellow ACO participants?
 - Can you describe the impact the real-life emergency had on your ACO's ability to ensure continuity of care for your patient population?
- C.** Do you have any lessons learned from these experiences that you can share with me?
- D.** Did you make any changes to your policies, procedures, or protocols based on these experiences?
9. Do you know how to reach your region's healthcare coalition?
- If yes, has your ACO engaged in any of the healthcare coalition's activities or are you aware of any engagement by your participants?
10. Is the facility or practice in which you work or are any of your fellow ACO participants subject to the Centers for Medicare & Medicaid Services (CMS) Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers Final Rule?
- What challenges, if any, has your facility encountered in meeting those requirements? How has your facility overcome those challenges?
 - Are you aware of any similar challenges encountered by other participants of your ACO?
 - Has being part of an ACO made it easier for your facility or other ACO participants to meet the CMS Emergency Preparedness Requirements? Please explain.
11. Describe any resources or written procedures your ACO has to ensure effective operations during an emergency. For example, during a disaster or emergency does your ACO have plans or procedures to share personnel/staff and resources to support care coordination and continuity of patient care?
12. Describe your ACO's procedures for communicating with its ACO participants in advance of, during, and following an emergency.
13. How would ACO leadership or other ACO participants be informed if an emergency overwhelmed the ability of one or more ACO participants to continue to provide healthcare services?
14. What kind of emergency preparedness training is available across your ACO, if any? How about in your practice/facility?
15. Have any preparedness exercises been conducted that involve the entire ACO? If so, what types? How about in your practice/facility?
16. Does your ACO have a business continuity plan in place?
- If yes, please describe some of its key elements.
 - Have you activated the plan during either a real-life emergency or a drill or exercise?
17. If your ACO were to incorporate additional emergency preparedness activities into your operations do you think these activities would improve the ACO's beneficiary experience? If so, how?

18. What policies, processes, or procedures are you aware of that would allow you and other ACO participants to support care coordination and continuity of patient care through an emergency or disaster?
19. What factors might pose an obstacle or challenge to the involvement of your ACO or its participants in an emergency response? Can you explain why that might be a barrier to involvement?
20. What would make it easier for you to improve emergency preparedness in your facility/practice and across your ACO?
21. Has your facility/practice or your ACO developed any emergency preparedness policies, procedures, or other resources that you would be willing to share through ASPR TRACIE with other ACOs?