

Capitol Region Emergency Planning Committee
RESF-8 Health and Medical
Hospital Subcommittee
June 4, 2008
East Hartford Public Safety Complex
East Hartford, Connecticut

Present

Robert Falaguerra, *Chairman – Saint Francis Hospital;*
Vicky Golebs(sp?), *Hospital for Special Care;*
Cressy Goodwin, *Recorder;*
Laura Nagle, *Bristol Hospital;*
Kris Pagano, *The Hospital of Central Connecticut;*
Mark Petrone, *John Dempsey Hospital;*
John Shaw, *Capitol Region MMRS;*
John Stonoha, *Hartford Hospital;*
Mary Turley, *Hospital for Special Care;*

Mr. Falaguerra opened the meeting at 11:40 a.m. He had obtained from DPH and distributed the signature pages of the *State of Connecticut Emergency Management Hospital Mutual Aid Agreement* signed in 2007 by the 12 hospitals in the Capitol Region (Middlesex, Central CT, Johnson Memorial, John Dempsey, Rockville General, Manchester Memorial, Children's Medical Center, Special Care, St. Francis, Hartford, Bristol and Natchaug.) A question was asked last month if these agreements need to be reauthorized annually. A clause in the agreement was remembered that authorizes these to remain in effect until written notice is given. It was noted that one hospital's agreement was signed by the CEO who is no longer at that institution.

Mr. Falaguerra next distributed the updated listing of the emergency contact telephone numbers at each Connecticut hospital. This includes listing the primary staff who would probably be serving in the significant command and general staff positions in the hospital command center. The listing for the Northern Tier hospitals shows several with incomplete information, and Mr. Falaguerra will continue to send reminders to complete this listing.

Mr. Falaguerra reported on a conference telephone call with Mary Duley at DPH the day before where contract deliverables and funding were discussed. He stated that in the 2008-2009 contracts there are many deliverables concerning alternate care sites. He raised three questions to gain clarification during this call:

1. *Staffing:* In a situation where there is the need for alternate care sites, there won't be sufficient resources to fully staff 10 to 12 alternate care sites in the region. Ms. Duley suggested that neighboring hospitals may wish to consider a shared alternate care facility to lessen the staffing and cost burdens on each institution. As the group discussed staffing, several other options were developed.

- a. Planning frequently assumes staffing in an epidemic must conform to day-to-day medical care standards. Once it is openly identified that an altered standard of medical care has to be expected, a new barrier emerges – planning for austere care by hospital personnel is difficult because the issues of liability, federal and state regulatory requirements, reimbursements and ethical issues all emerge.
- b. **A basic issue was identified: who is authorized to plan for staffing the ACS: hospitals or the community? This has not been clarified as a policy issue, making it difficult to initiate and support a planning process.**
- b. Dr. Shaw identified the reality - when hospitals become overwhelmed, the delivery of care should follow a public health model – minimal care to the population serving the maximum number of people affected.
- c. At the Noble Training Center at Anniston, Alabama, a document is used defining alternate standard of care for a pandemic flu event. Staff from Bristol Hospital recently returned from this program, and **Ms. Nagle stated she would see about sharing this document defining a more limited standard of care with the group. This could be the beginning of our logistics planning effort.**
- d. There is a need to clearly identify the exemption of regulations and standards and provide liability protection when this is needed. **It is assumed that the statutory authority authorizing the Governor to declaring a public health emergency provides these protections. It was agreed to request DPH conduct a review of the statute to identify if the following is covered:**
 - i. **Explicit authority to waive standards of care regulations;**
 - ii. **Authorization for reimbursement for care that is rendered;**
 - iii. **Protection against civil liability for medical decisions reached after such a declaration is made.**

If these protections are not in current Connecticut statutes, it is recommended that legislation be developed to provide them. The California plan for alternate care sites cites that state's statutes that could serve as a model.

- 2. *Regional supplies:* In the next DPH contract cycle, there will be funding for regional supplies. During the conference telephone call, a request was made of Ms. Duley to create a summary general listing of state resources, where they are and how one can call to request these. This information will be needed before a hospital or a region can identify what resources are needed and not already in reserve to prepare these contracts. **The group agreed to support this request listing of state level resources that are already available to hospitals during an influenza epidemic.**

3. *Mass Fatalities Planning.* During the conference telephone call, Ms. Duley was asked if there is any new information on the statewide planning for mass fatalities. She indicated that work is continuing but there is nothing available yet to report. **Mr. Stonoha announced that on Friday, June 6, 2008 a meeting has been called with state and regional stakeholders to begin the development of a regional mass fatalities plan.**

Mr. Falaguerra reminded the group that Dr. Shaw needs guidance on the framework of a regional pandemic flu plan. He suggested we do this by describing the sequence of escalating activities in response to a local mass casualty situation (with a sudden onset and a limited geography) and a pandemic influenza (developing over time, and widespread. Discussion led to the following:

Mass casualty situation (a roof collapse in an arena in Hartford with 5,000 casualties):

- Local public safety responders arrive at the scene and establish the incident command system.
- Hartford area hospitals activate their plans and begin surge management activity (delaying elective procedures, early discharging, expanding staffing and resources, *etc.*)
- Activation of the RED Plan.
- State DPH is notified, other hospitals in region are alerted.
- Patients are triaged at the scene, and the worst are transported first.
- Hartford area hospitals approach capacity – decisions are made by the Transport Officer at the scene to send patients to other hospitals in region – CMED coordinates transportation and communications.
- As the travel time to more distant hospitals increases, more ambulances are mobilized.
- Critical patients requiring immediate definitive care are sent to the nearest available hospitals, holding less critical patients at the treatment area. An option that may emerge spontaneously might be a medical team (from a local hospital or from LIFE STAR?) being sent to the scene to provide definitive care.
- As more patients are delayed in the treatment area it begins to function as a “casualty collection area.” This could become apparent an hour into the event and could last up to 4 or 6 hours. This would function as an equivalent to an “alternate care site.” **Formal activation of alternate care centers would not be required for a local mass casualty event** because there are still hospital resources available although at a distance to provide the appropriate standard of medical care. Also the need for this temporary facility is limited and would be temporary.
- Consideration given to activating the Forward Movement of Patients Plan.
- Consideration given to mobilizing the mobile hospital – which could be activated, deployed, set up and staffed in 4 or more hours.
- Consideration given to requesting a DMAT team activation to support medical care at the scene – to supplement the “casualty collection area” established earlier.
- Consideration given to request NDMS activation to provide air evacuation from Bradley International Airport to hospitals in other regions of the country.
- Recovery begins.

Pandemic Influenza (outbreak identified elsewhere a month earlier and observed over time – the first patients are now appearing at hospitals in the region.)

- State – DPH – regional – local – hospital communications are already established.

- Hospital surge preparations are well established (delaying elective procedures, early discharging, expanding staffing and resources, *etc.*)
- By anticipating the expected patient volumes ahead of time, decisions are reached to prepare for alternate care sites. The number of sites that will be needed can also be decided during the growing epidemic. **It was agreed that setting up these sites should start before there is a declaration of a public health emergency.** This has to be a balanced decision – it can save hours and days of logistics time delays, weighed against the costs of setting up sites if they are not actually used. **Once set up, however, no patients can be received and treated until a public health emergency is declared.**
- **It was agreed that triage of patients has to be done at the hospital, not at a remote centralized local or regional triage facility.** Patients suffering only symptoms of influenza could be sent back home with instructions or to the alternate care site, and might not usually be admitted to the hospital. Available hospital resources could then focus on critical trauma and other acute medical patients who present for care.
- **Communications between hospitals and the supporting emergency operations centers up to the state level can coordinate any hospital's need for the declaration of a public health emergency if it has not yet been decided.**
- It can be assumed during a pandemic, it is not likely that hospital resources in other parts of the country will be available. Neither would other medical resources in New England, New York and New Jersey. This limits the application of the NDMS federal resources, and the implementation of the regional Forward Movement of Patients Plan.
- The more austere standard of medical care can be identified later filling in the planning needed to define the staffing, equipment and supplies needed for the different ACS.

The group agreed to adopt this discussion as an outline for a regional pandemic influenza plan. The comparison with a local MCI response clarifies the roles of alternate care sites and hospital triage during an epidemic. **It is essential to this planning that statutory authority for the governor to declare a public health emergency includes health care facility and staff exemption from regulatory requirements, allows for reimbursement and protects against civil liability for those rendering medical care.**

The meeting adjourned at 1:28 p.m. The next meeting of the Hospital Subcommittee is scheduled for July 2, 2008 at 11:30 a.m..

Respectfully submitted,

Cressy Goodwin, MPH
Recorder