

Capitol Region Emergency Planning Committee
ESF-8 Health and Medical - Leadership Meeting
August 1, 2007
East Hartford Fire Department Training Room
School Street, East Hartford, Connecticut

Present

John Shaw, *Chairman*
Scott Aronson, *Russell Phillips and Associates*
Ron Buckman, *Capitol Region Medical Reserve Corps*
Carmine Centrella, *CRCOG*
Mariann Cherniak Lexius, *Manchester Health Department*
Kristen Dean, *CRCOG*
Robert Falaguerra, *St. Francis Hospital and Medical Center*
Tom Gavaghan, *DEMHS Region 3*
Cressy Goodwin, *Hartford Hospital*
Steve Huleatt, *West Hartford, Bristol Health Department*
Hank Klein, *North Central CT EMS Council*
Katherine McCormack, *Capitol Region Medical Reserve Corps*

Dr. Shaw opened the meeting by stating there are two critical issues that the ESF-8 group needs to address next year:

- The leadership of this section – its structure and organization.
- Integrating the ever-increasingly complex programs that continue to expand.

He also announced that in two weeks the chiefs of all the CREPC ESF sections will be meeting – this group serves as the steering committee of the Metropolitan Medical Response System (MMRS).

John proposed a primary objective to focus the work of the ESF-8 section in the next 12 months: “To develop and implement a comprehensive surge capacity plan to provide support for the medical needs of our communities when the traditional healthcare system has been compromised.” Specifically included would be the identification of alternate care sites (facilities) in DEMHS Region 3, and development of a system of community support for those sites (facilities) when activated.

During the discussion, the need was expressed to be more precise about the terms we are using. For example, “*surge capacity*” is a general term that has been used by different groups to convey subtly different meanings: hospitals overrun by patients; or public health clinics having excessive demands, or physician offices having to schedule new patients months in advance. Dr. Shaw reinforced that “*surge capacity*” is not just a hospital issue. It is a community issue as well. “*Alternate care sites*” is another commonly used term with varying meanings implying for some regulated medical facilities to provide added capacity to augment hospital care; or implying for others community based locations where “wards” can be set up to provide non-emergent medical care; or for yet others, shelters where supportive or palliative care (or public health quarantine or isolation) can be provided to those people who do not need medical care yet cannot remain at home.

It was suggested that by working to develop a comprehensive system defined by overlapping but discretely different alternative functions could become increasingly difficult.

It was noted that this and other major initiatives we are working on have been defined as contract deliverables for federal funding to hospitals, and local health departments/districts. It was also noted there is a tendency to develop these initiatives with unchallenged theoretical assumptions of the problems and conditions that will be present when they are to be implemented. As a result, there is little emphasis on creative problem identification and resolution in the systems that are to be developed. Such systems need to be functional. Care is needed to focus on what the issues are these systems will need to address within our communities and region. Not only does CREPC need to focus on what the kinds of problems such a system should be developed to address, this same consensus is needed at the state level as well.

Three generalized definitions were suggested:

- **Medical and surgical surge capacity** describes the ability of existing medical resources in an area (community, region, state) to meet the needs of an expanding number of people perceiving or actually needing medical care. When the population of people demanding or needing such care exceeds the capacity of the existing healthcare system, that system needs to be augmented. *This is not a static number but recognizes the fluidity of patient demands and shrinking/expanding facility and staffing levels over time.*
- **Alternate care sites (facilities)** define the alternate locations where patient care can be rendered including nearby hospitals with available beds; early release of recovering patients to nursing home and extended care facilities; transfer of stable acute patients to distant facilities; or to non-traditional locations where “wards” can be created to match the defined clinical needs of the population to be served. *This term is not used just to define the non-traditional locations for such augmented care.*
- **Forward movement of patients** defines the mechanics of moving patients between clinics, hospitals and alternative care sites (facilities). *This term is not just to define the movement of large numbers of patients from one or more hospitals to destinations outside of the region. It includes diversions, early discharges, and transfers to decompress the heavily impacted facilities as well.*

Another factor for success was identified: these systems planning issues involve a variety of different “stakeholders.” From community leaders, hospital administration, local public health officials and EMS services, there are many points of coordination that are needed. It was suggested that the ESF-8 goals be stated as an integrated, functional system, identifying the roles different groups will need to play. Then work is needed to constantly educate / explain / train all the partners as to their expectations in the developing of a functional system.

Dr. Shaw raised three questions for the group:

1. Is there a consensus that this primary objective is what we want to do?
2. Are the leaders in ESF-8 prepared to work on these issues?
3. Do we feel this objective can be accomplished?

After a discussion, a general consensus was reached that we should continue to address this objective, and that the group of leaders would support the work required. Mr. Centrella expressed concern over the possibility of failure citing that there is no clear definition of the problem that is driving all this effort – we do not have a precise picture of what we are trying to achieve.

Mr. Goodwin offered to work with Mr. Centrella and others to draft a strategic discussion paper defining the problems, scenarios and situational context as an analysis to guide the further development required. This report will be submitted to the ESF-8 group at a later date. It was agreed to go ahead with the initial efforts to designate the alternate care sites (facilities) while this analysis is being developed.

Mr. Aronson stated the need to develop a consistent message about this program. There was agreement that the initial PowerPoint presentation on alternate care facility designations presented at the last CREC meeting should be expanded and offered to other groups. Mr. Goodwin offered to assist in this.

Ms. Dean asked for guidance. In mailing out the Toolkit, it was suggested she send this for information to all CREPC members. A separate letter will be drafted to send to the hospitals and the local health departments/districts requesting it be used. Mr. Falaguerra stated he was scheduling a meeting in the very near future for representatives of the 4 hospitals and local public health department in Hartford to coordinate a combined effort to survey and identify the needed number of sites in the City. It was noted that the hospitals have until August 15 under their HRSA contracts to report to DPH the sites that have been identified – this is just two weeks away.

The group next reviewed strategic proposals from each of the sections in the ESF-8:

Medical Reserve Corps (MRC)

Ms. McCormack identified that at the beginning the members of the MRC were listed as hospital-based staff. The MRC membership has now grown to include community-based practitioners. Dr. Buckman strongly reinforced this concept. Work for the next year will include:

- Development of core competencies for the MRC to serve in various identified capacities during a disaster.
- Develop a curriculum to address these needs.
- Implement training programs for MRC personnel through the CREPC ESF-8.
- Identify leaders within the various disciplines to be delegated responsibilities.
- Recruit an expanded number of members.

- Identify funding sources available – we are at the point where full time staff support will soon be needed to carry on the required expanding activities.
- Finally, there will be the need to coordinate the regional MRC development with statewide efforts to create a broader MRC program.

Metropolitan Medical Response System (MMRS)

Dr. Shaw identified the projected activities for MMRS for the next year:

- Satisfy the stated “deliverables” identified in the grant we have received.
- Maintain the operational capabilities we have previously developed.
- Review and be prepared to address new projects selected from the “Target Capabilities List” being developed nationally.
- Enhance pharmaceutical security.
- Advance the “City-Readiness” program efforts.
- Further develop and implement training curricula.

Central Medical Emergency Deployment (CMED)

Ms. Morris identified the work the North Central Connecticut CMED will be undertaking this next year. (There are two CMEDs that cover the CREPC / DEMHS Region 3):

- Make functional the goal that in an emergency, there would be one primary CMED in each of the 5 DEMHS regions to strategically implement EMS / hospital communications.
 - Plans developed to share staff and other resources as needed between the two CMEDs.
- Develop and implement a standardized training program for CMED operators addressing the unique needs and services required during a disaster.
 - Perhaps extend this training to local E911 Public Safety Answering Point communications staff.
- Evaluate and if indicated, develop enhanced electronic data processing and transfer from the scene of a disaster.

Emergency Medical Services (EMS)

Dr. Shaw summarized a meeting that was held the day before in which EMS initiatives were discussed:

- Implement the training programs being developed now for EMS personnel at a disaster scene.

- Explore ways to enhance electronic data transfer from the scene of a disaster while remaining compliant with federal HIPAA regulations preserving patient confidentiality.

Local Health Departments and Districts

Mr. Huleatt summarized the local public health activities for next year:

- Provide all the deliverables required under the separate CDC grant.
- Begin efforts to standardize planning and operations between the 19 different health districts and departments in the region. (*e.g.*, to describe and define “points of delivery - PODs” structure and operations the same for Hartford as for Manchester, *etc.*)
- Initiate an integration of activity with community health centers and long term care facilities. (*e.g.*, educate local facilities what the communities pandemic influenza plans call for them to participate.)
- Identify what training beyond NIMS compliance training might be needed to support community health centers and long term care facilities to meet their expected roles.
- Establish one or more regional strike teams to respond to a disaster situation to assist in responding to public health and sanitation issues.
- Develop an inter-regional protocol or communications plan or algorithm to allow communities in the other DEMHS regions to appropriately request assistance from CREPC ESF-8 local public health resources if this is needed.

Mr. Huleatt identified that the Connecticut Association of Departments of Health (CADH) has been assured of continuing funding from CDC for emergency preparedness programs for the next two years. However, there will be some funding cuts and consolidation in various areas, and it is quite apparent that long term federal funding is not a realistic expectation. One outcome of this is the reduction in the number of planned vaccination sites (PODs) in our region from 12 to 8. This is not just determined by funding restrictions, however. Federal guidance is now offered that each site can be expected to address the needs of a population of 150,000 to 200,000 over several days instead of the previous assumption of only 50,000.

Hospitals

Mr. Falaguerra outlined the priority activities anticipated over the next year for hospitals”

- Each hospital was to have developed a written surge capacity plan in which the number of additional beds are identified that could be made available over time by flexing their early discharges, delaying elective procedures and transferring some patients to long term care facilities. These documents will be collected or other mechanisms identified to have each of the hospitals in the CREPC region pool their data to identify the number of reserve beds that could be created over time within the region itself.

- This information will be used to establish a predictive mechanism to anticipate when the need is approaching for alternate care facilities to be activated – before the hospitals capacities are actually reached.
- The current work will continue to identify the alternative care sites (facilities) for each community or hospital where this is needed.
- The development of a study of the logistics, staffing and functional activation of the alternate care site (facilities) will also continue.
- The forward movement of patients planning will be continued within the context of the implementation of the alternate care site (facilities) project.
- It is hoped that a hospital senior management conference/program can be developed in the next twelve months to explain to hospital leadership the importance of integrating emergency management with community planning and responses.

Overall ESF-8

Dr. Shaw stated again that a goal for next year for the ESF-8 section will be to identify leaders from each of the sections who can be expected to respond to the RCC during any emergency situation. Part of this effort will be to train these people to become part of the regional Incident Management Team to coordinate health and medical responses along with others.

In response to a question, Dr. Shaw stated that the CREPC program for coordinating exercises will continue as it had in the past year.

Respectfully submitted,

Cressy Goodwin
Recorder