Capitol Region Emergency Planning Committee
RESF-8 Health and Medical – ***Hospital Section***
January 21, 2009
East Hartford Public Safety Complex
East Hartford, Connecticut

Present

See attached attendance list

The meeting opened at 11:40 a.m.

Review of hospital planning for 2009 HSEEP Exercise Project:

Dr. Shaw requested the group discuss policies or issues that the regional Homeland Security Exercise and Evaluation Program (HSEEP) project could address once a vendor is contracted to plan for a series of three exercises ending in the fall.

The group inventoried those present and found representatives of 9 hospitals were at the table. The Hospital for Special Care will be contacted later to review the discussion. One topic was addressed that would be useful for evaluation in a regional exercise – external sources for support and supplies. Hospitals have memoranda of understanding (MOUs) with vendors and suppliers in an emergency. It is suspected that many of these have contracts with multiple hospitals. The question arises how adequately these vendors can meet everyone's needs. To limit the complexity of the planning for these exercises, the group decided to focus on just a few types of supplies – simultaneously asking for these from vendors during the exercise. The following were recommended:

- Water
- Food
- Expendable medical supplies (gowns and masks)
- Pharmaceuticals
- Cots

An objective could then be to test the ability of vendors to deliver these items in a reasonable time to all who make requests.

Mr. Falaguerra recommended that all hospitals submit their vendor MOUs to allow these to be summarized on a spreadsheet. From this, an initial evaluation can be made about vendors who may have over-committed.

Review of Planning for Alternate Care Sites:

Mr. Falaguerra distributed a document from DPH providing answers to questions previously raised about Alternate Care Facility (ACF) planning (attached). During the discussion, several issues were raised that may require further clarification:

1. If local health departments have a role assisting a hospital in its planning, what are the requirements for a health district or community department like Hartford with one health department and more than one hospital?
2. The outline for making a decision to open an ACF appears to be very complicated with several different steps and groups involved. A question was raised that some time earlier, a decision was reached that when the Governor declares a public health emergency, this would be the only authority. There are also legal and reimbursement issues for all who authorize an ACF to be opened.
3. The state guidelines are based on a model that provides patient triage at a central location remote from the region's hospital. More discussion is needed to make this concept workable. It was pointed out that patients living near a hospital who do not have transportation will not be able to travel to a regional center. And even if the logistics for staffing and transportation are worked out, hospital triage staff will still have to remain available – many in the public will still come directly to the nearest hospital seeking care.
4. Where triage is accomplished, who makes the decision for destination hospital? Does the patient have any choice? What regional or state system is there to identify and allocate the available beds – and centrally manage these assignments?
5. What systems are needed to provide coordinated transportation of patients at an ACF who become sicker and have to be taken to a hospital?
6. The previously raised question about who provides staff to the ACF is not answered for the clinical and support staff – more discussion on this is needed.

It was noted by one hospital representative present that if they reach maximum surge capacity, their response would be to shut the doors and not accept any new patients. They do not have the staff and the equipment to open their ACF. This leads to the need for a regional system to share and coordinate resources. Greater details for regional planning need to be addressed by the state. It was observed that currently in DEMHS Region 3, there are 10 hospitals and 10 separate plans. Moving toward regional coordination and sharing is clearly indicated.

Respectfully submitted

Cressy Goodwin
Recorder

ATTENDANCE:

CREPC ESF-8 HOSPITAL SECTION Meeting

January 21, 2009

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QUESTIONS FOR FACILITATED DISCUSSION on ACF
December 1, 2008 12-2pm

1. Who is ultimately in charge of the alternate care facility? Hospital, public health, etc?

An ACF that is opened by a hospital for the purposes of enhancing their inpatient care capability, by either off-loading stable patients or receiving patients from Triage Centers, will be considered as "under the umbrella of that particular hospital's administration". In essence it becomes a satellite of that hospital. During the planning process both the ACF and the LHD need to work together to help assure the appropriate allocation of staff and resources for these facilities.

2. Who makes the final decision to open an alternate care facility?

This will be a decision made by the acute care hospital in concert with local planning partners (LHD, EMD, local VNA, HCA, to name a few of the community planning partners) and with DPH input based on the overall statewide situation. This will be a process un-rolled in steps – most likely starting with the opening up of Triage sites long before any hospital has reached it's maximum surge capacity, or individual hospitals or a pair of hospitals in some circumstances gearing up to open an ACF in a community within the facility's catchment area

3. What level of care is expected to be provided at the alternate care facility?

The function of alternate care facilities is to provide basic care to stable, lower-acuity patients unable to take care of themselves at home. As outlined in detail on page 4 of the ACF: Statewide Approach Planning Guidance the following activities could/would potentially take place at these facilities: Monitoring of condition to include basic vital sign measurement, temperature, pulse, respiration, blood pressure, pulse oximetry, basic care of ADLs (activities of daily living) to include assisting in hygiene, elimination, meals. Provide and maintain hydration: oral and potentially simple IVs (no IV pumps) provide medication delivery (likely patient's own medication), +/- antiviral agents, +/- antibiotics, and basic point of care testing, urine dips, and glucometer…

4. What kind of supplies will be needed? If medical supplies are needed, such as IV, who is responsible for obtaining the supplies?

a. Recommended Equipment: (outlined on page 4 of the ACF: Statewide Approach Planning Guidance)

- Durable equipment – cots, wheelchairs, IV poles, walkers, chairs, tables
- Medical equipment – thermometers, blood pressure cuffs/machines, glucometers, pulse oximetry devices, emergency carts, AEDs, medication refrigerators, locked medication storage
- Medical supplies – emesis basins, bedpans, urinals, commodes, wash buckets, personal protective equipment (masks [+/- respirators?], gloves, gowns, etc), personal hygiene supplies, hand hygiene products, IV Fluids on hand.
- Communications – telephones, computers, fax, copiers, 2-way radios
- Office supplies – charts, pens, paper, pencils, staplers, paper clips, etc.

b. At this point the hospitals have been provided monies for supplies needed within the hospitals for increased surge, the State has begun purchasing cots and linens for the

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regions for ACF's, and in many cases LHDs have also begun to stockpile some equipment for same. My recommendation would be to increase this purchasing in the upcoming year, and the State will be doing the same.

5. Who determines where the alternate care facility will be - may not necessarily have to have more than one site open?
This will be a decision made by the acute care hospital in concert with local planning partners (LHD, EMD, local VNA, HCA, to name a few of the community planning partners) and with DPH input, based on the overall statewide situation.

6 Who determines where patients will be transported? Is it up to EMS dispatch to make the determination based on the phone call that they either go to the hospital or alternate care facility? Will there be an algorithm developed by DPH that can be used to make the determination of where to take the patient?
A Pan Flu Annex to the Statewide EMS Mobilization Plan will be under development shortly. This annex will outline in detail the process whereby the determination is made as to where, if anywhere, a patient will be transported during an influenza pandemic. The Pan Flu Annex will outline the transport of all patients during an influenza pandemic, not just the patients experiencing flu s/s. Yes, an algorithm will be developed by DPH that can be used to make the determination of where to take the patient.

7. Deaths may occur in the alternate care facility. Is there a protocol that should be followed on how to properly handle/dispose of bodies?
The MFM Taskforce is in the process of developing the flowcharts for the proper handling/disposition of bodies for both in and out of the hospital, and will provide these recommended protocols to the local planners once complete. Updated MFM Planning Guidance is expected to be released prior to the end of December 2008. Next MFM Taskforce Meeting is December 16th. At that meeting recommendations will be decided upon by the group for multiple local planning questions that have arisen since the original planning guidance was released in the Spring of 2008.

8. What role does DPH play in re: to alternate care facilities?
As outlined on page 1 of the Guidance DPH will provide guidance and technical assistance as requested.

9. Has DPH had discussions with the appropriate parties as to their roles and responsibilities for opening an alternate care facility and the anticipated challenges that they will face at the local level?
Yes, since 2006 all of the State's acute care hospitals that participate in the Dept of Health and Human Services (DHHS) Hospital Preparedness Program (HPP) and have been recipients of its funds have been made aware of their roles and responsibilities for not only identifying sites, but also for opening up an alternate care facility and the anticipated challenges that they will face. To that end, in anticipation of the hospitals coming forward with their many concerns during the planning efforts, DPH has been instrumental in doing the following: 1. Developing the ACF Planning: A Statewide Approach document in collaboration with the Yale New Haven Health System OEP; 2. Multiple planning tools and

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guidance has been provided to the hospitals and their respective planning partners, a few examples developed by AHRQ being: "Providing Mass Medical Care with Scarce Resources: A Community Planning Guide", "Altered Standards of care in A Mass Casualty Event"; and 3. In January 2008 DPH Commissioner Galvin convened an Advisory Workgroup, comprised of ethicists, clinicians, local and state public health professionals and lawyers. This Advisory Workgroup is co-chaired by Donna Brewer and Marianne Horn, two of DPH's legal staff. The responsibility of this workgroup is to identify key ethical, legal and practical principles to guide decision-making for health care delivery during mass casualty events such as an influenza pandemic. The DPH will use these guiding principles to assist the public in gaining advance understanding of the choices that will need to be made if such an event occurs. These principles will also assist the provider community to avoid sustaining punitive responses as a result of their involvement in caring for the victims of a mass casualty and/or pandemic influenza.

10. Who will oversee the alternative care sites?
How is this question different from Question #1?

11. Is this the responsibility of the hospitals, to provide a skeletal crew as public health has been told, or is it the responsibility of local public health, as the hospitals have been told?
The hospital provides administrative oversight to the facility in addition to at least one individual per shift with clinical competency, ideally an experienced ED or ICU RN, capable of Triage or able to supervise triage staff for a Triage Center and/or an ACF site providing sub-acute care. Recommended staffing for both ACF Triage Model and ACF Lower Acuity Patient Care Model provided in detail on pages 3-4 of the ACF: Statewide Approach Planning Guidance.

12. Will the hospital supply medical personnel to triage those in need of medical care to send them to the hospital or the alternate care facility?
ACF Triage Model (Triage Centers) are an additional planning component that acute care hospitals, in concert with their community planning partners, need to come up with protocols for as they prepare for an Influenza Pandemic. DPH has provided planning guidance for this on page 3 of the ACF: Statewide Approach Planning Guidance.

13. How will the alternate care facility/hospital communicate and who will decide if the status of a patient in one facility changes such that the patient will have to be sent to the other facility?
The ACF and hospital will communicate by a variety of methods: walkie-talkies, cell phones, POT lines, internet, to name a few. This communication should be part of the pre-event planning currently taking place. The most senior/experienced medical person on-staff at the ACF would be the one to decide if a patient would be sent home, sent to the hospital for more definitive care if there is available space, or deciding if palliative care is the most appropriate option. Ideally this individual would be an experienced ED or ICU RN, or a comparable individual (perhaps even a physician extender, such as a PA or an APRN), or ED MD.