Duke Healthcare Preparedness Coalition General Meeting

NC Triangle Coalition
HEALTHCARE PREPAREDNESS

DHPC
CAPRAC
MID CAROLINA

October 27, 2017

SECRETARY REPORT

Key Dates

- **Hazard Analysis Review and Steering Committee meeting –** December 14, 2017 (9am -4pm) McMahon United Methodist Church
- **Quarterly Coalition Meeting** (3rd Qtr.), January 27, 2018 (1:00-4:00pm)
- **Quarterly Coalition Meeting** (4thQtr.), April 28, 2018 (1:00-4:00pm)
- **Steering Committee Meeting –** (Work plan Review) May 2018, TBD.
- **Coalition Surge Test** – **Unannounced exercise to be conducted between June 11-15, 2018.* ***Facilities wishing to participate should contact the Coalition***

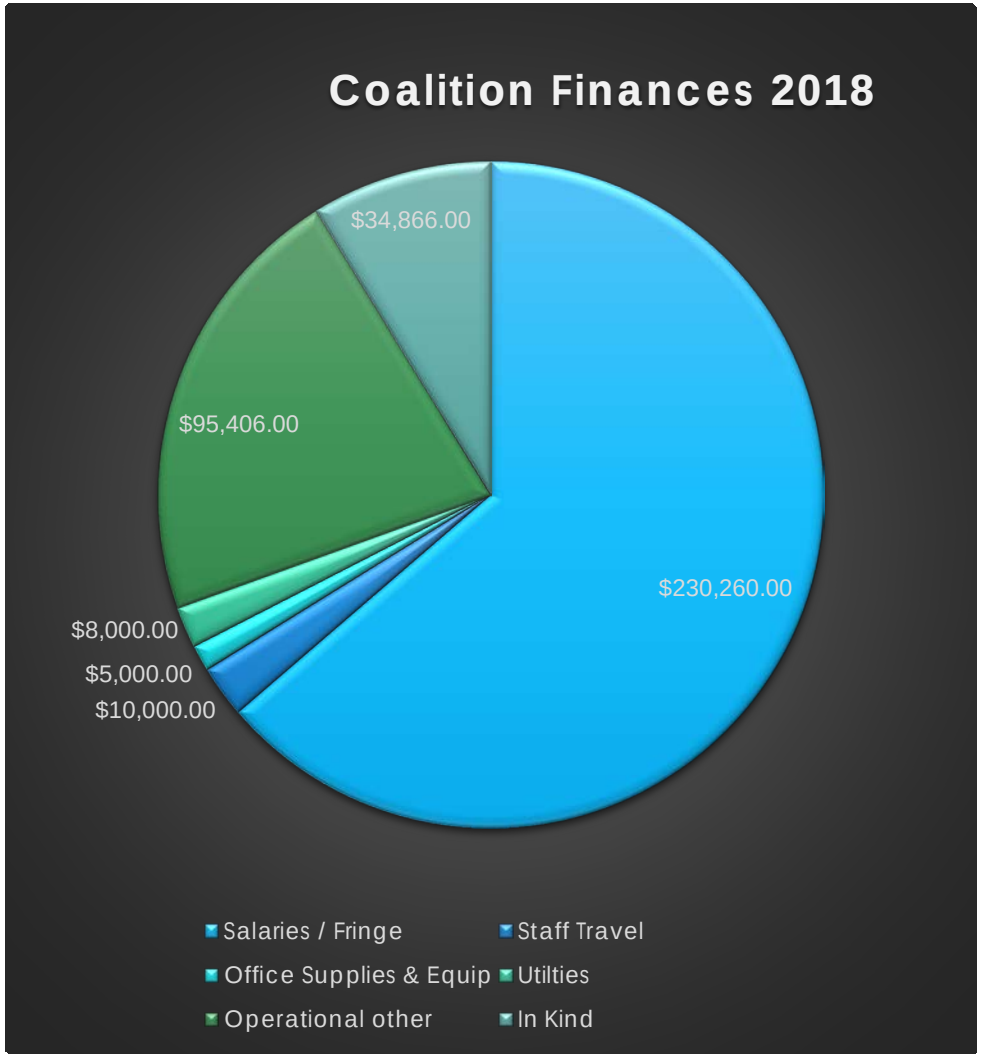
EDUCATIONAL OPPORTUNITIES

- **Healthcare Coalition Conference, November 28-30, San Diego, Ca**
- **Joint Commission Emergency Management Conference, April 18-19, 2018, Orlando Fla.**
- **NACCHO Conference, April 17-20, 2018 Atlanta Ga.**

TRESURER REPORT

COALITION UPDATE:
Grant Financial Management 2017 -2018

Salaries / Fringe	$230,260.00
Staff Travel	$ 10,000.00
Office Supplies & Equip	$ 5,000.00
Utilities	$ 8,000.00
Operational other	$ 95,406.00
In Kind	$ 34,866.00
Total	**$383,533.00**



Duke HPC FY17-18 Budget Summary

	Approved/Revised Budget	Reimbursement to Date (September)	Balance	Committed	Projected	Unallocated
Administration = Salaries, fringes, travel, office supplies, and utilities	$ 253,260.00	$ 47,288.58	$ 205,971.42	$ 3,342.65	$ 7,701.85	$ 194,926.92
Capability 1 - Foundation for Healthcare and Medical Readiness	$ 33,406.00	$ 721.65	$ 32,684.35	$ 842.04	$ 827.96	$ 31,014.35
Capability 2 - Healthcare & Medical Response Coordination	$ 5,000.00	$ 27.17	$ 4,972.83	$ 2,465.00	$ -	$ 2,507.83
Capability 3 -Continuity of Healthcare Service Delivery	$ -	$ -	$ -	$ -	$ -	$ -
Capability 4 - Medical Surge	$ 57,000.00	$ 6,530.83	$ 50,469.17	$ 4,075.54	$ 20,094.57	$ 26,299.06
Total	$ 348,666.00	$ 54,568.23	$ 294,097.77	$ 10,725.23	$ 28,624.38	$ 254,748.16

Total Award	$ 348,666.00	Per Cent Expended	**15.65%**
Expended to Date	$ 54,568.23		
Balance	$ 294,097.77		
Committed	$ 10,725.23		
Projected	$ 28,624.38		
Unallocated Funds	$ 254,748.16		

CHAIRMAN’S REPORT

CAUCUS UPDATES

- EMERGENCY MANAGEMENT
- EMERGENCY MEDICAL SERVICES
- PUBLIC HEALTH
- HOSPITAL
- COMMUNITY HEALTH CENTERS
- HOME / HOSPICE
- LONG TERM CARE / SKILLED NURSING

SUB-COMMITTEE REPORTS

- ❑ Health Care Coalition Development and Sustainment (Ken Shaw)
  - ❑ REGIONAL HAZARD ASSESSMENT
  - ❑ COALITION ASESSMENT
- ❑ Communication, Training and Outreach (Courtney Polomsky)
  - ❑ WEBSITE
  - ❑ NOVEMBER ACTIVITIES
- ❑ Logistics, SMAT, and Disaster Response (Will Connor)
  - ❑ LOGISTICS WORK DAY VOLUNTEERS
  - ❑ SMAT TEAM UPDATE

SPECIAL COMMITTEE REPORT

GOOD & WELFARE

Medical Surge Planning for Healthcare Organizations

DUKE HEALTHCARE COALITION

OCTOBER 27, 2017

Agenda

1. Review project purpose and workshop topics
2. Survey results
3. Identify improvements
4. Key discoveries

Project Purpose

Medical Surge Project Overview

GOAL: Prepare for the Coalition Surge Test

- Annual, Low / No-Notice test
- Simulate evacuation of 20% of staffed acute care beds (to match IBA)
- Performance Measures

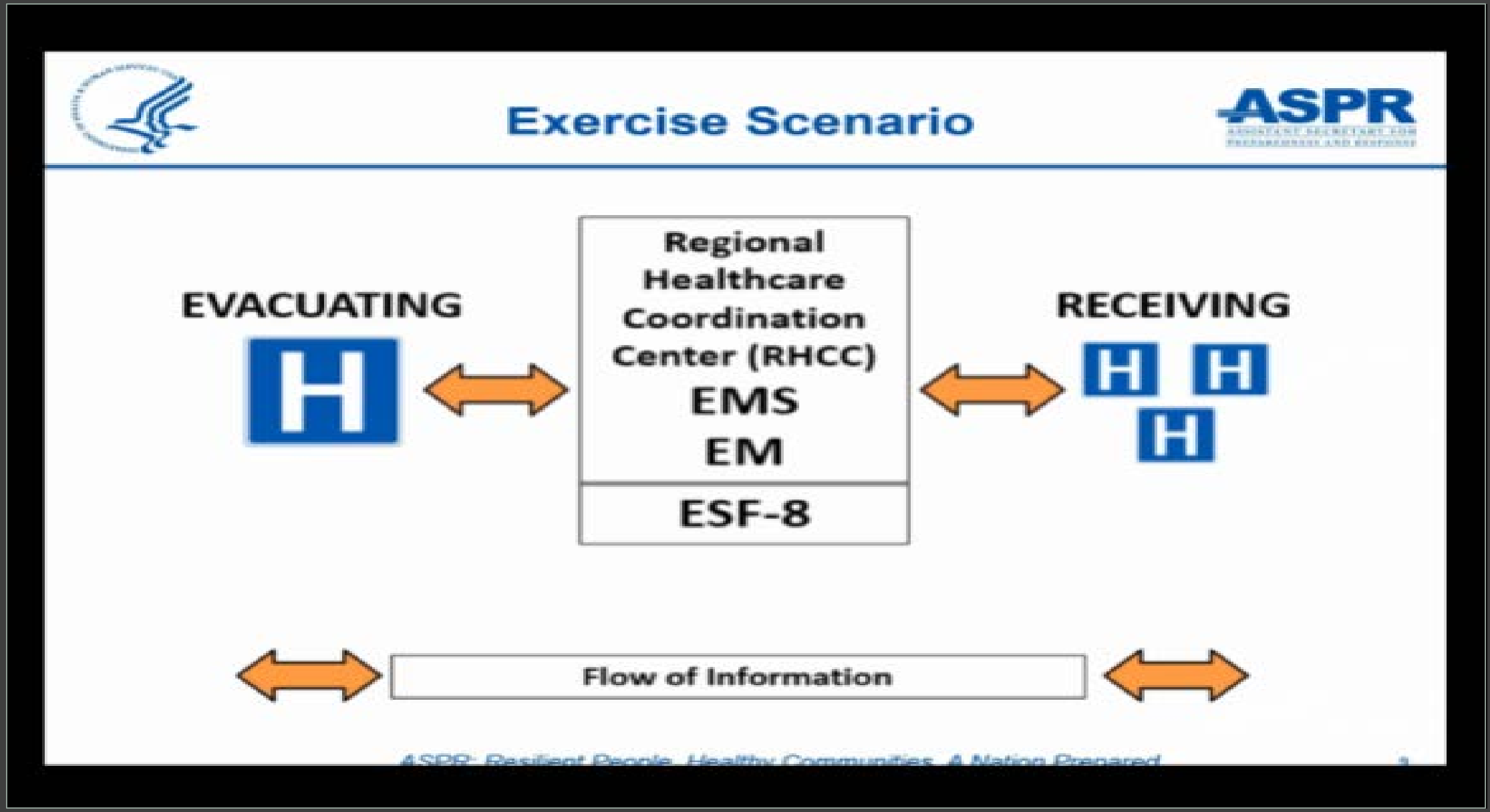
HCC Objectives

Collaborate and coordinate with health care response entities to identify clinically appropriate beds for evacuating patients.

Communicate and coordinate with medically appropriate transportation.

Identify essential elements of information that help inform situational awareness among HCC members and partners.

Scenario: Hospital Evacuation



HPP Capability #4: Medical Surge

OBJECTIVE 1: PLAN

1. Incorporate surge planning into health care organization EOP.
2. Incorporate surge planning into EMS EOP.
3. Incorporate surge response in HCC response plan.

OBJECTIVE 2: RESPOND

1. Implement ED and inpatient surge response.
2. Implement out-of-hospital surge response.
3. Develop an alternate care system.

Medical Surge Performance Measures

- **PM7:** Percent of hospitals with an emergency Department (ED) recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies.
- **PM13:** Time (in minutes) for evacuating facilities in the HCC to report the total number of evacuating patients.
- **PM14:** Time (in minutes) for receiving facilities in the HCC to report the total number of beds available to receive patients.
- **PM19:** Percent of patients needing to be evacuated to another health care facility with a bed identified at a receiving facility in 90 minutes.
- **PM20:** Percent of patients with clinically appropriate transportation needs identified in 90 minutes.

The Duke Coalition's Medical Surge Project

1. **Seminar 1: Introduction – July 28, 2017**
2. **Workshop 1: Healthcare Organization Medical Surge Planning – October 27, 2017**
3. **Workshop 2: EMS Medical Surge Planning – January 26, 2018**
4. **Workshop 3: Duke Coalition's Role in Medical Surge Planning – April 27, 2018**
5. **Webinar 1: Project Review – May 4, 2018**
6. **Workshop 4: Mitigation Strategies for Medical Surge – May 24, 2018**
7. **Coalition Surge Test – June 14**

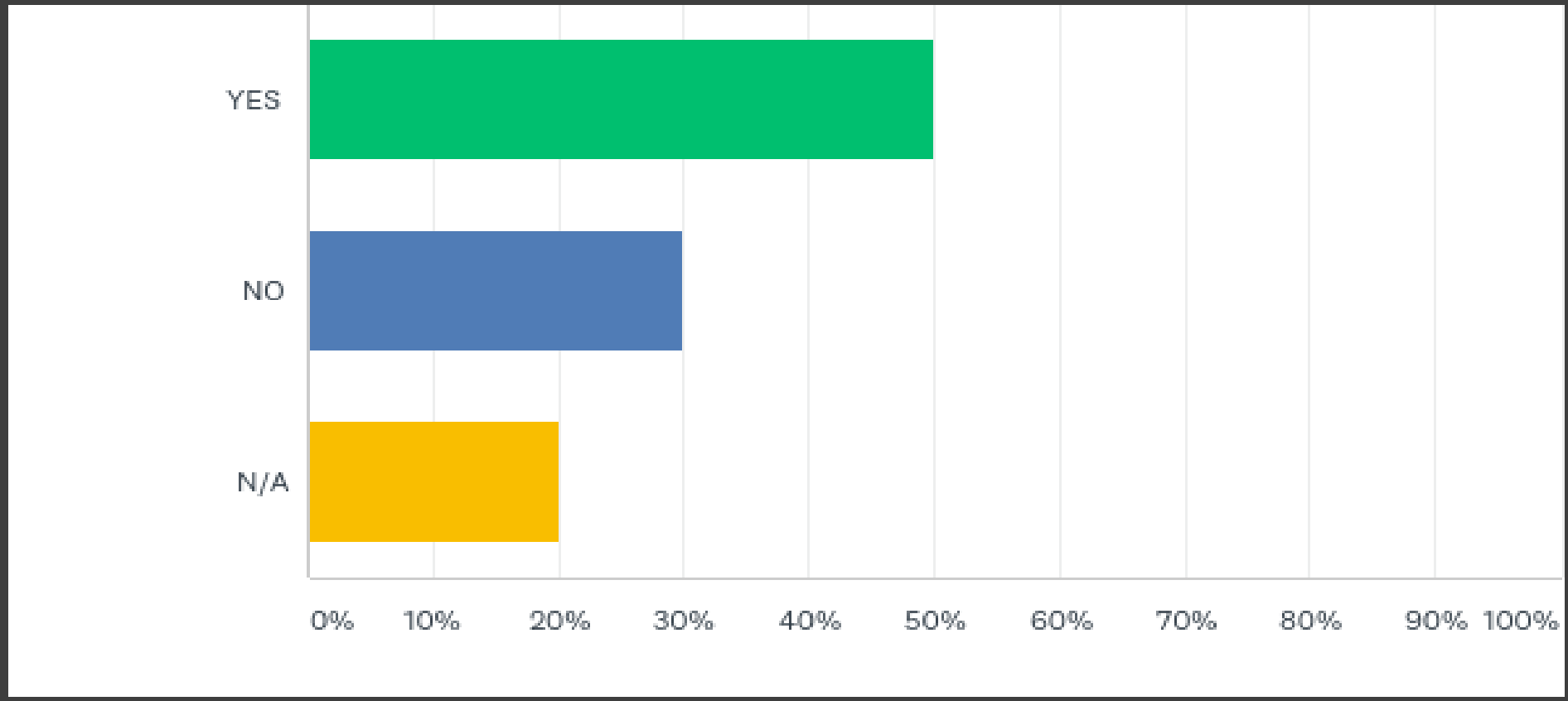
Workshop Topics: Healthcare Organizations

Workshop Topics

Objective 1, Activity 1: Incorporate medical surge planning into healthcare organization emergency operations plan

Objective 2, Activity 1: Implement emergency department and inpatient medical surge response.

Current Medical Surge Planning in the Duke Coalition



Q2: Does your facility have a medical surge plan as part of your Emergency Operations Plan (EOP)?

Q3: When was the last test of your surge plan (a real event or an exercise)?
Enter the month and date below.

- October 4, 2017
- July 2017
- October 2017
- Real event, April 28, 2017
- October 2016
- N/A
- N/A
- N/A
- N/A?
- never

Q4: What are the top 3 gaps that you have identified in your facility's surge plan (not related to coordination with the Coalition)?

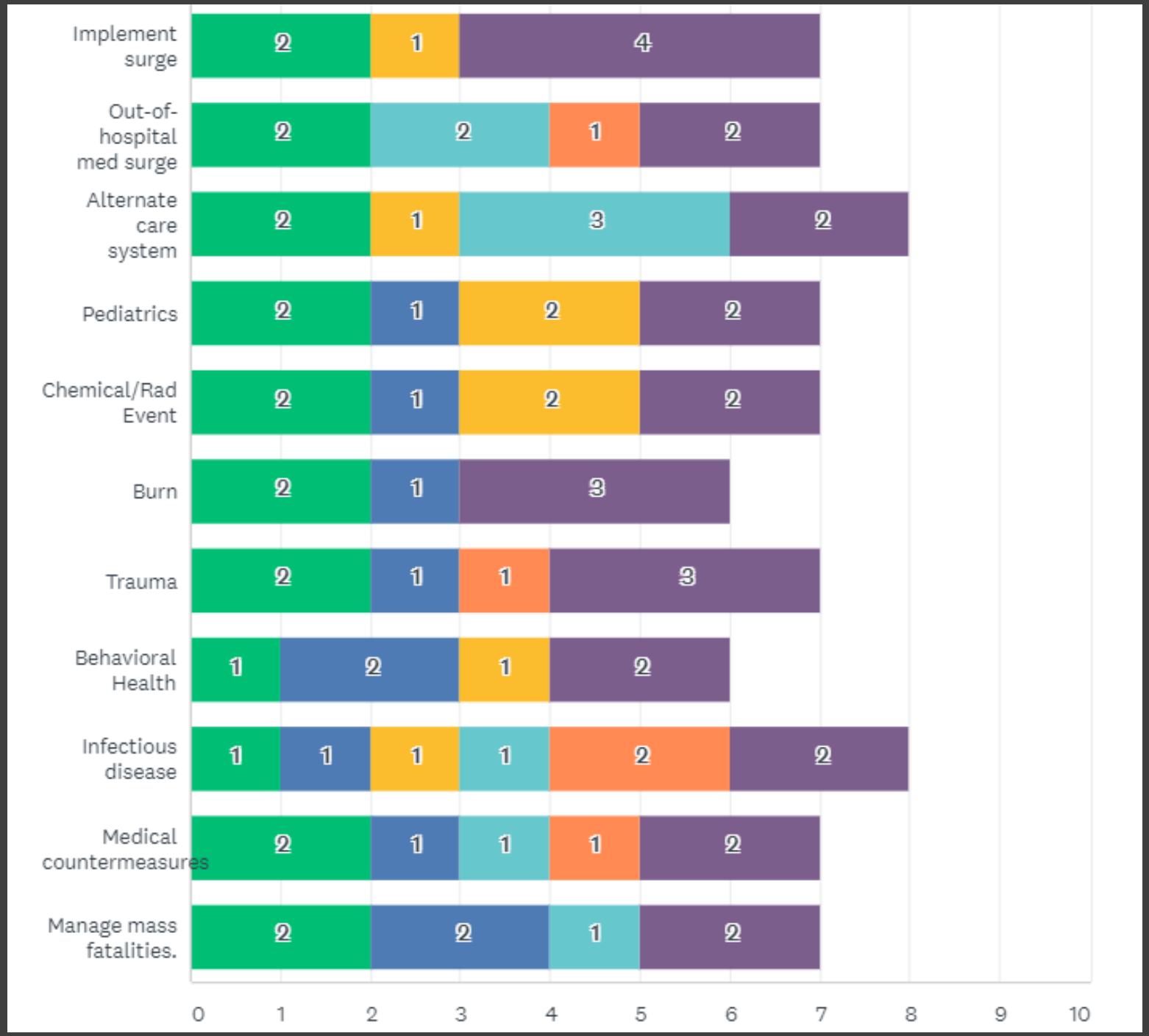
- 1) Better coordination between the Public Information Officer and the Public Information Coordinator. 2) Better coordinated logistics support. 3) More screeners needed.
- 1) Availability of Nursing Staff to complete admission visits. 2) Communication of patient schedules/demographics with computer systems down. 3) Ability to contact high risk patients in the event that primary means of communication are disabled (phones)
- 1) Full capacity 2) Staffing 3) Pediatric capability
- 1) Staffing during incident initiation 2) Staff call back (lots of staff who live far away) 3) Alerting administration
- 1) HAZMAT Equipment 2) Staffing 3) Communication from Incident Command Center to staff
- Don't have a surge plan being a Hospice and Home Health provider

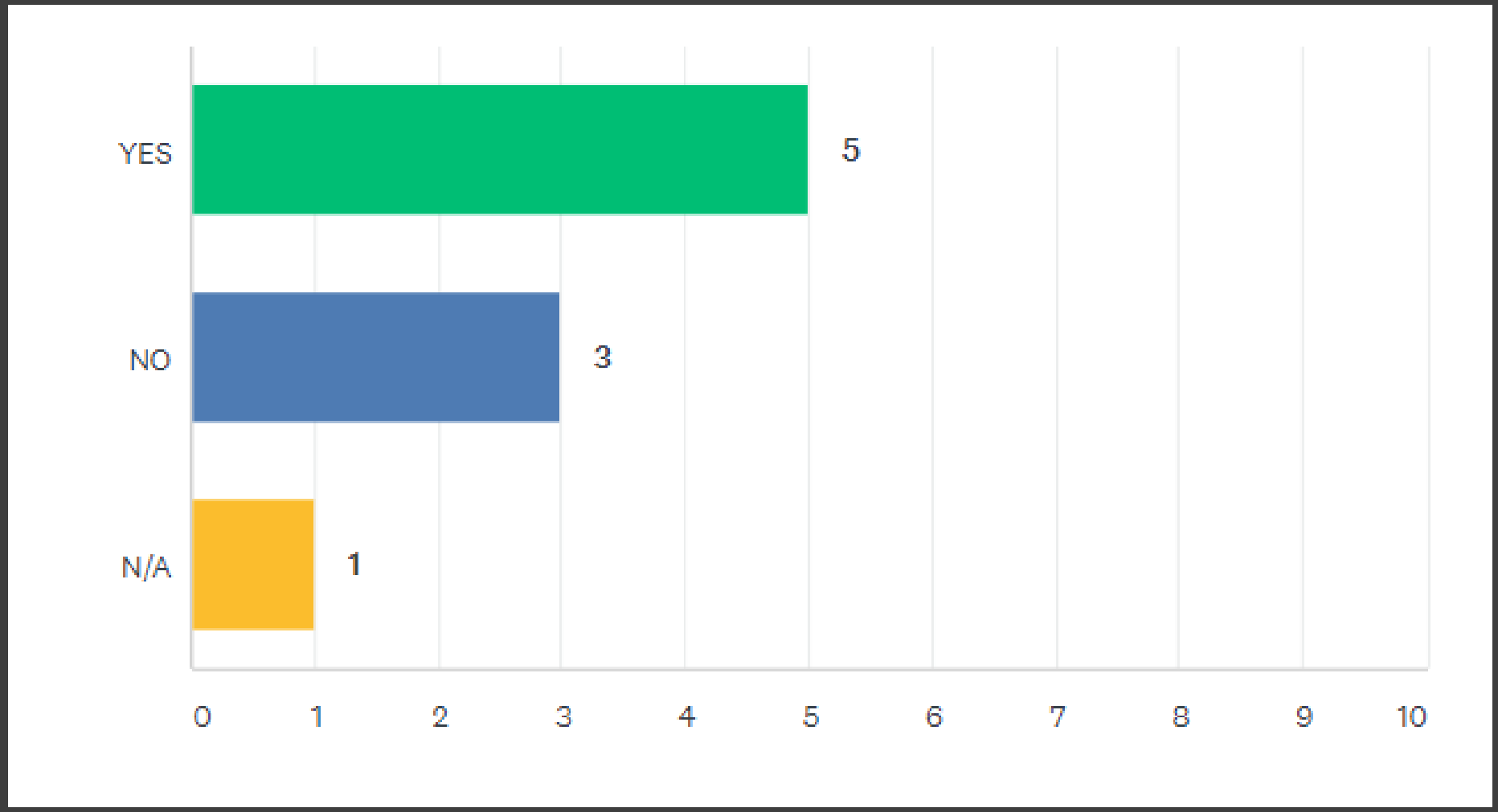
Q5: What are the top 3 gaps that you have identified in your facility's surge plan related to coordination with the Coalition?

- Five answered “N/A”
- 1) distance 2) response time
- Not sure
- The surge plan for us doesn't directly involve the Coalition, that is the only gap I can think of.
- 1) Staffing 2) Communication 3) Patient mobility/transfer/continuum of care

Q6: The following elements are part of the HPP Capability 4: Medical Surge. Rate your facility's ability to respond to the following types of patients.

1 is the lowest; 5 is the highest.



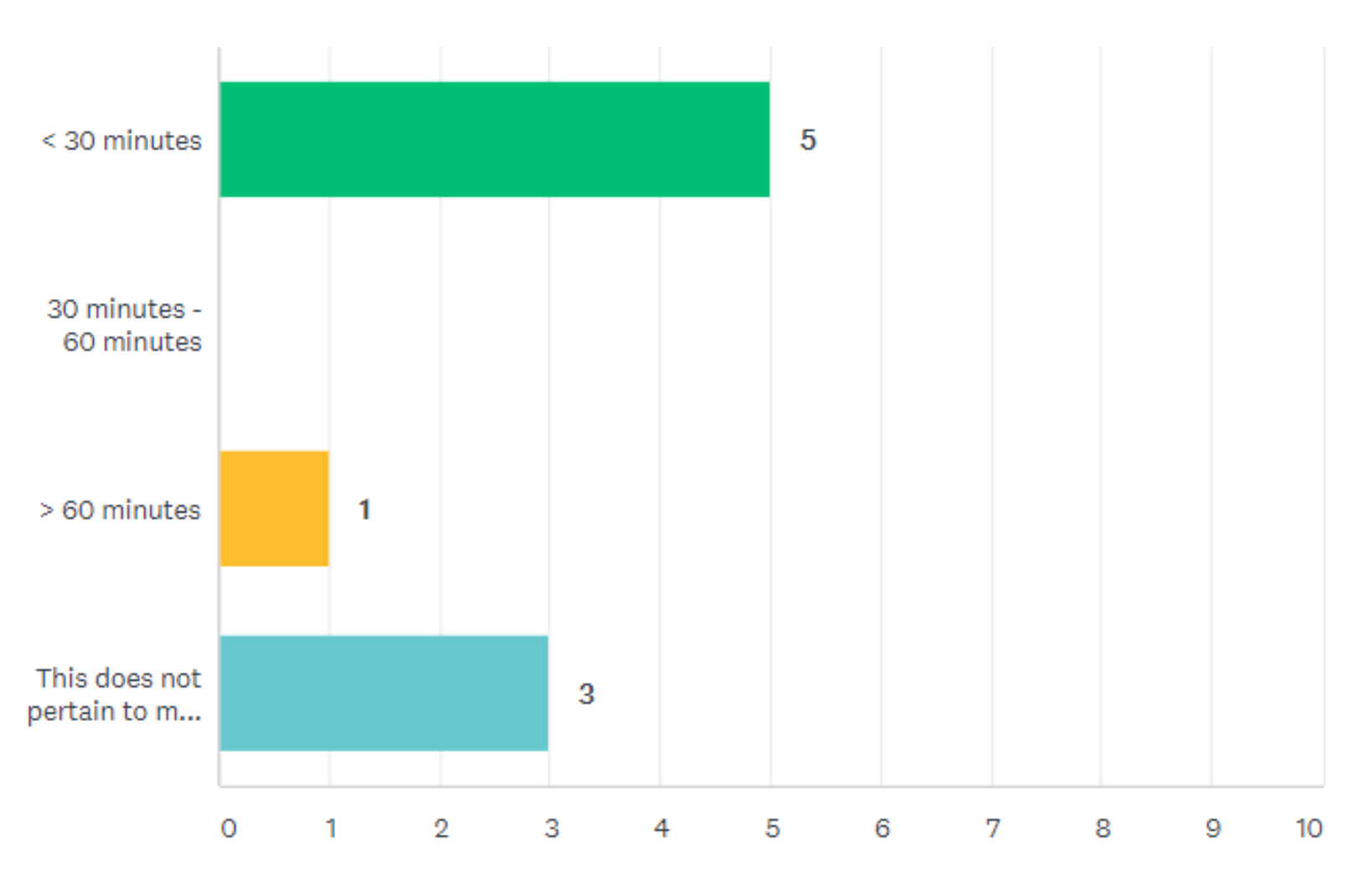


Q7: Does your facility accept pediatric patients on a routine basis?

Q8: What are the barriers to your facility's ability to accept pediatric patients in a medical surge event?

- We serve hospice end of life patients
- Health department staff are not trained to handle pediatric medical emergencies.
- No pediatric trained staff
- Only have one pediatrician available at two locations. Others work under the pediatrician. Limited hours of operation. Do not function as an emergency care center during medical surge events.
- Volume and additional equipment
- Since we don't typically admit peds patients, our staff are not trained on peds care and we don't have the facilities to care for critical peds patients
- Enough skilled professionals for peds care
- Staff education

Q9: As an estimate, how long would it take your facility to assess the number of patients for evacuation and report this information to the Coalition?



Q10: What are the barriers to your facility's ability to assess the number of patients and/or report this information to the Coalition?

Two answered “N/A”

If disaster involved widespread and unexpected loss of power/computer systems it would hinder our ability to rapidly pull reports of patient demographics and patients in need of evac.

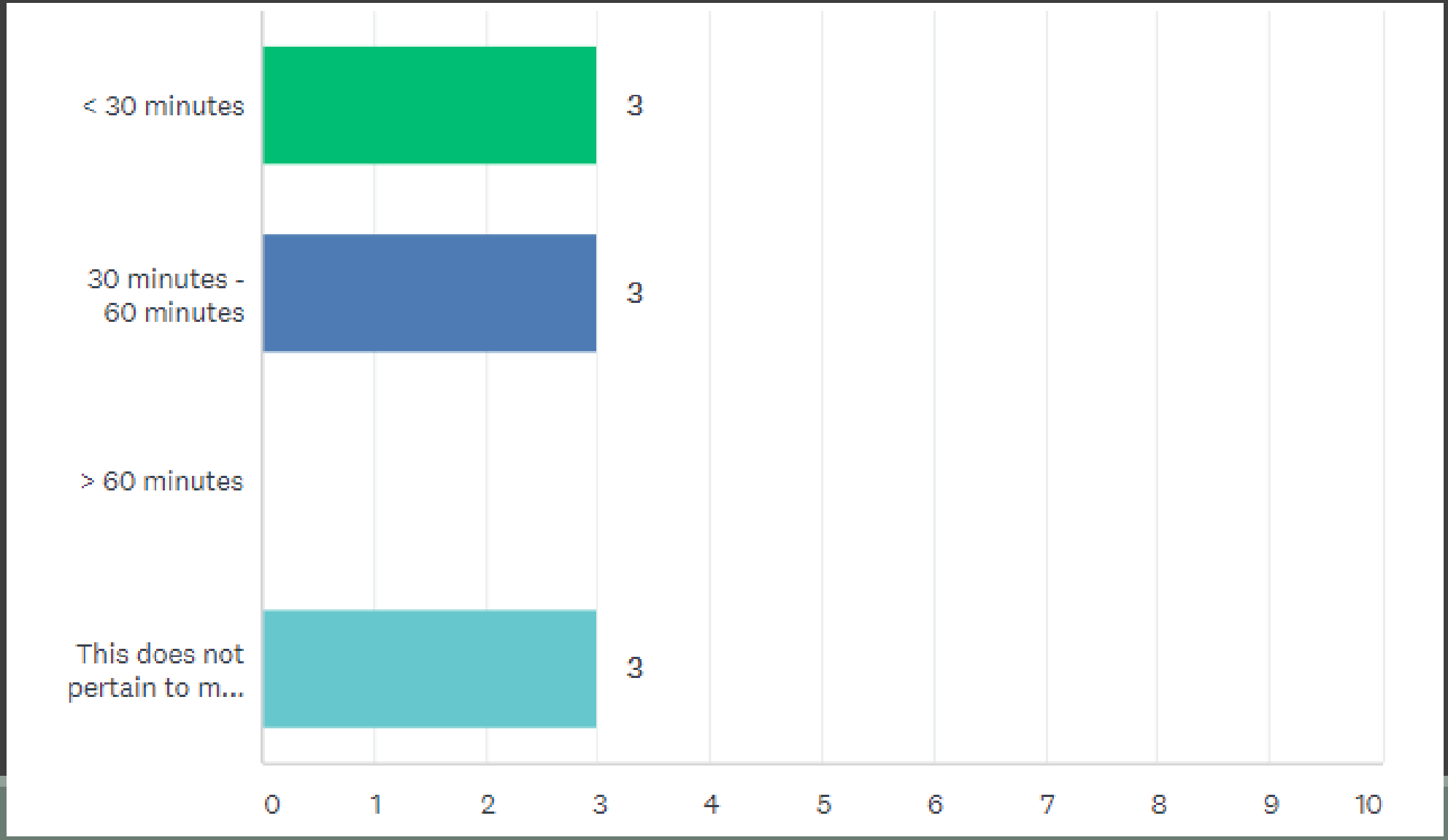
Do not function as an emergency care center during medical surge events at present.

None

No known barriers, would just have to include patients in inpatient units, ED, and long-term rehab/SNF unit.

Coordination and communication between all entities.

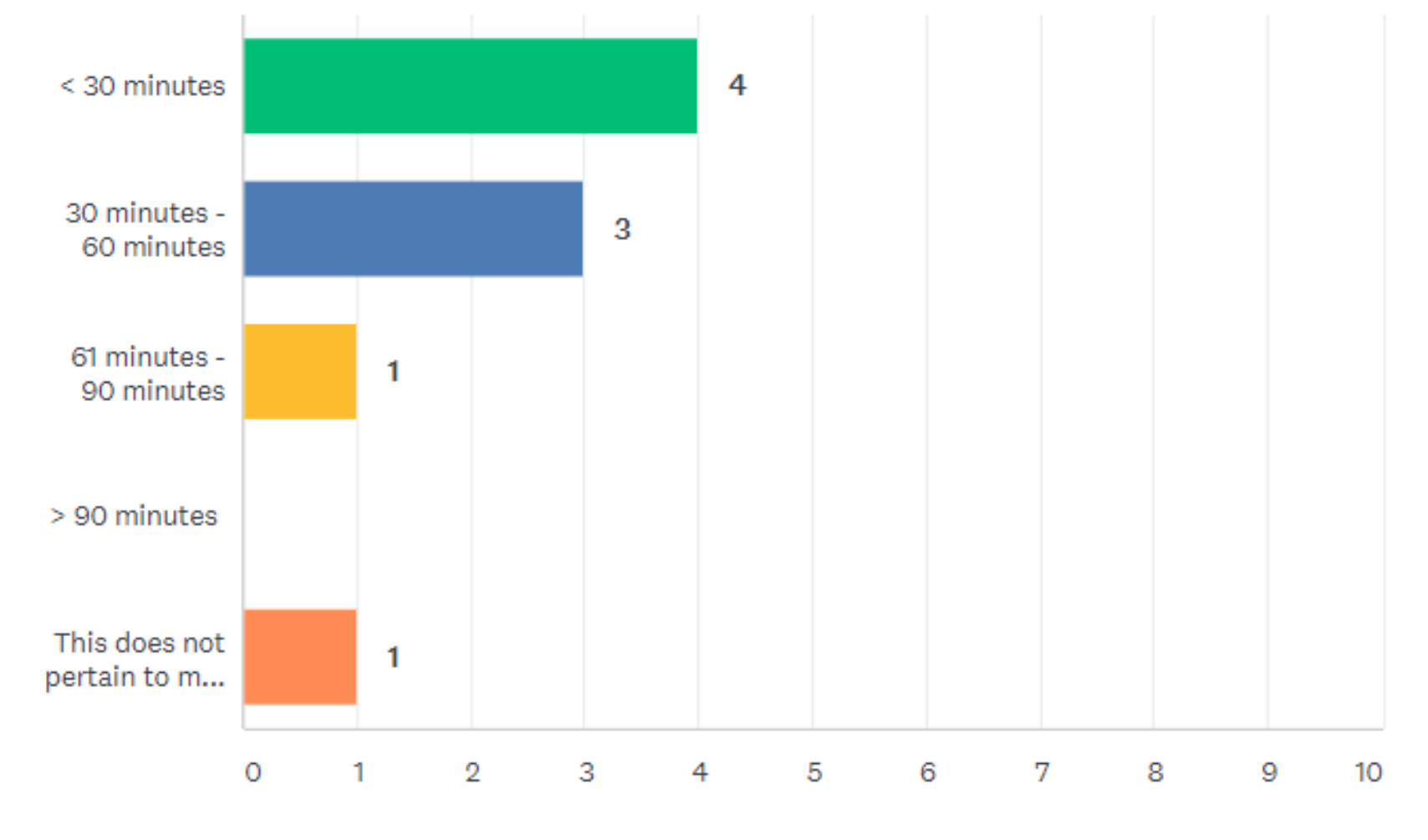
Q11: As an estimate, how long would it take your facility to assess the number of available beds and report this information to the Coalition?



Q12: What are the barriers to your facility's ability to assess the number of available beds and/or report this information to the Coalition?

- No barriers just time to assess existing planned admissions and available staff for covering additional patients
- Local public health staff will be working in the shelters and will report this type of information to the shelter manager.
- Home Health Organization
- Do not function as an emergency care center during medical surge events at present. The residential treatment services are open 24 hours a day and continue providing services for those that are already enrolled/engaged in care at these sites. RHCC does have the capacity to report the number of available beds but it is diagnosis specific (substance abuse) and gender specific as well.
- None
- Staff awareness of how to use SMARTT system to report bed availability
- Communication and training of staff

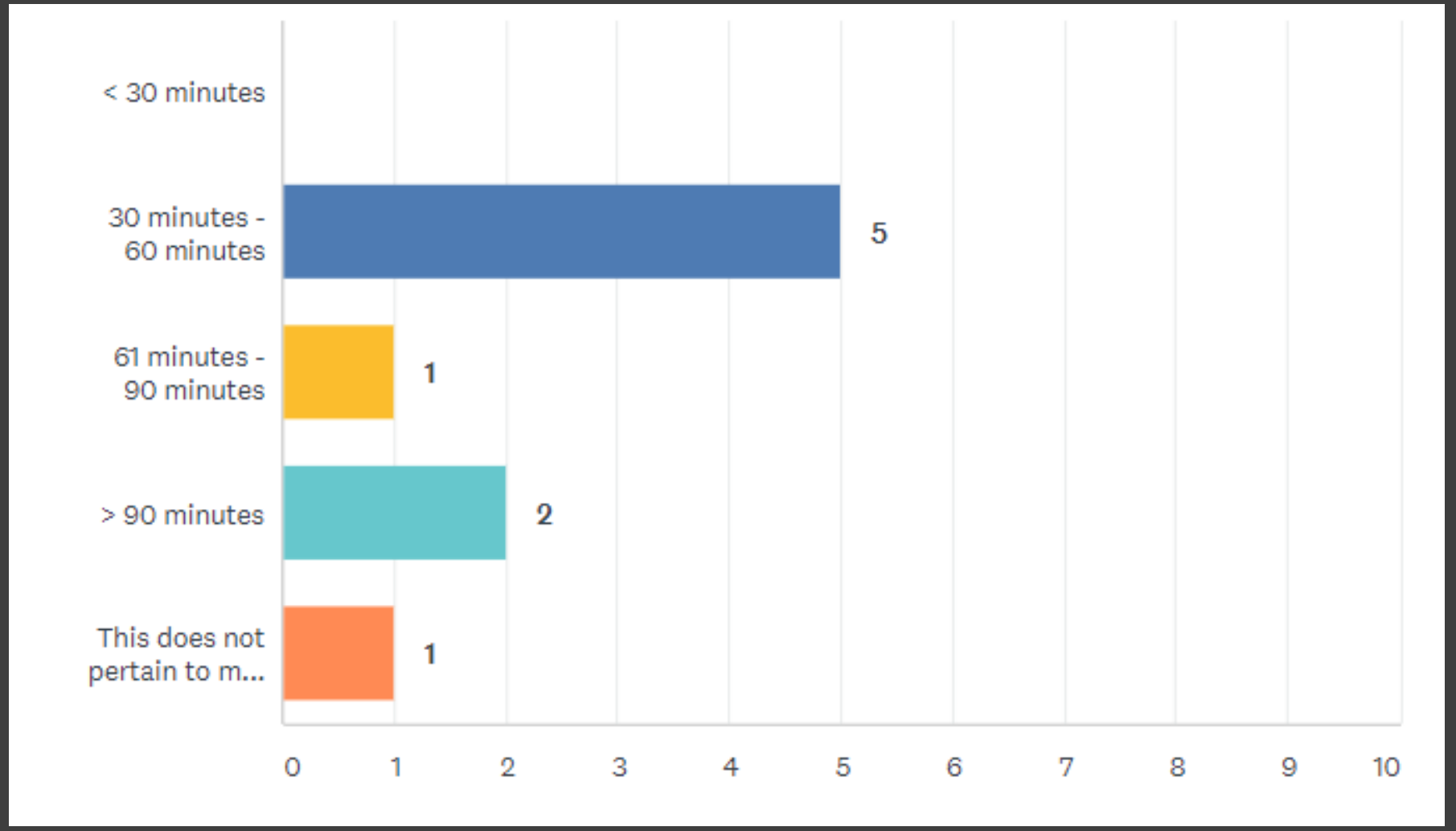
Q13: As an estimate, during an evacuation, how long would it take your facility to identify the number of patients that would need a bed in another healthcare facility and report that information to the Coalition?



Q14: What are the barriers to your facility's ability to identify patients that need a bed in another healthcare facility and/or report that information to the Coalition?

- During a shelter operation the local public health triage nurse will report to the shelter manager that a patient requires placement, the shelter manager will arrange patient placement in another healthcare facility.
- Identification of patients with communication to Case Managers and family dynamics in the home with respect to evacuation plans.
- Communication failure would be the greatest barrier.
- None
- No known barriers, we do a lot of transfers here and that process is pretty well hard-wired.
- Training and communication of staff.

Q15: As an estimate, how long would it take your facility to locate and request clinically appropriate transportation assets?



Q16: What are the barriers to your facility's ability to locate and request transportation assets?

- None, we can request transport the question is how we will be triaged due to the nature of our business (Hospice).
- During an event that requires sheltering, it may be difficult to arrange transportation using other county agencies.
- Identification of patients in need of transport and then identification of the resources to transport those individuals.
- Transportation assistance outside of the agency is limited or non-existent. Should a relocation be necessitated, agency personnel would most likely have to transport non-critical patients. Most sites are rural and may take extended time to locate and arrange transportation. Access may be gained through local ambulance/rescue -type services if a critical situation arose for patients with medical complications.
- Requesting transportation is easy, but actually getting the transportation may be tricky. Local EMS and private transport companies are limited in how many patients they can transport, and next closest hospital to send patients to is approx 40 mins away.
- Limited community resources, low socioeconomic patient demographics
- Ability to contact the patients

Q17: Any other comments about this medical surge project or gaps to be addressed by the Coalition?

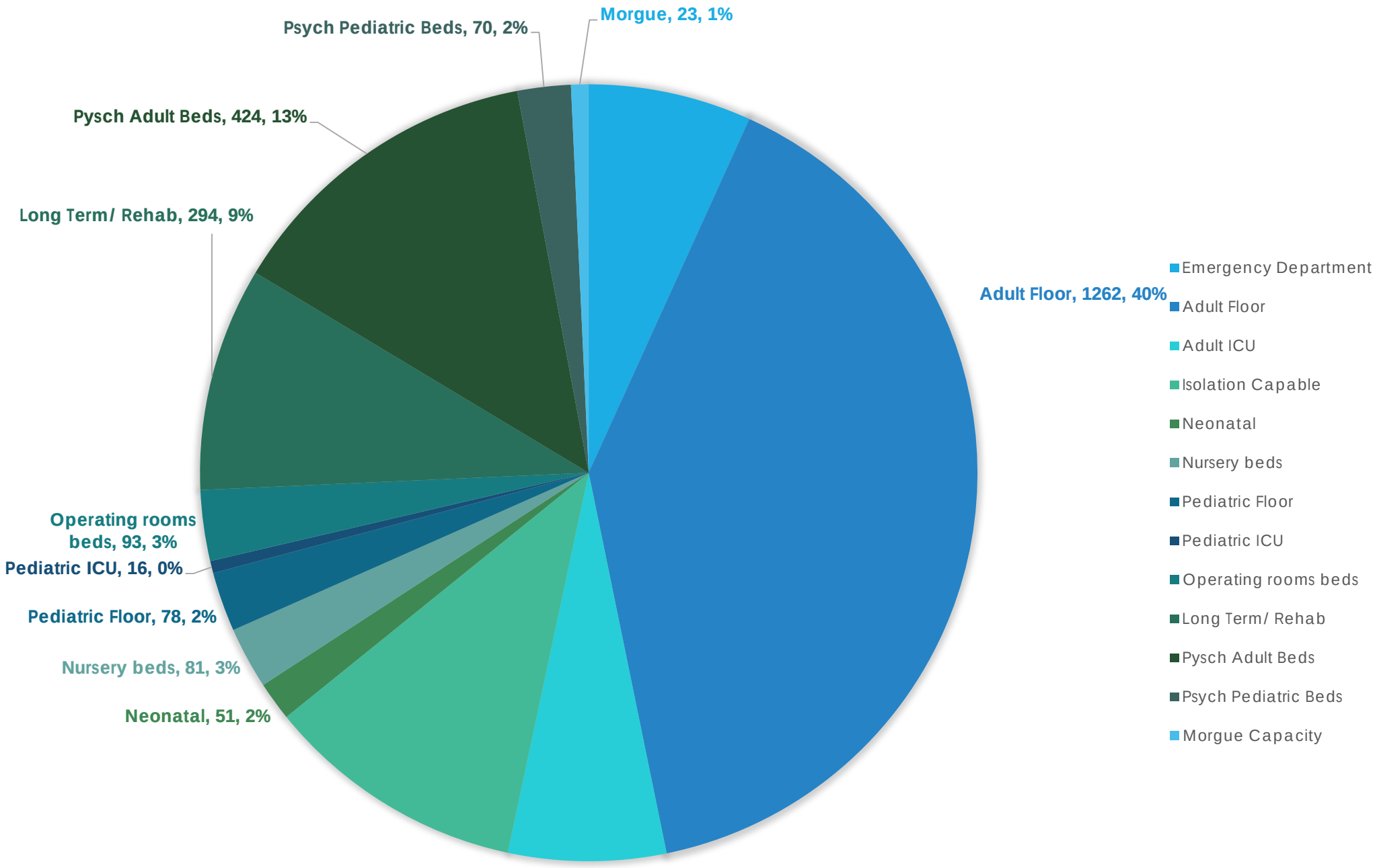
None

The survey is too long.

As we are a dialysis facility, we could assist other dialysis patients in need, but could not perform or care for any other medical conditions or needs.

Bed Availability:

The current baseline availability of regional healthcare beds as Identified in NC SMARTT

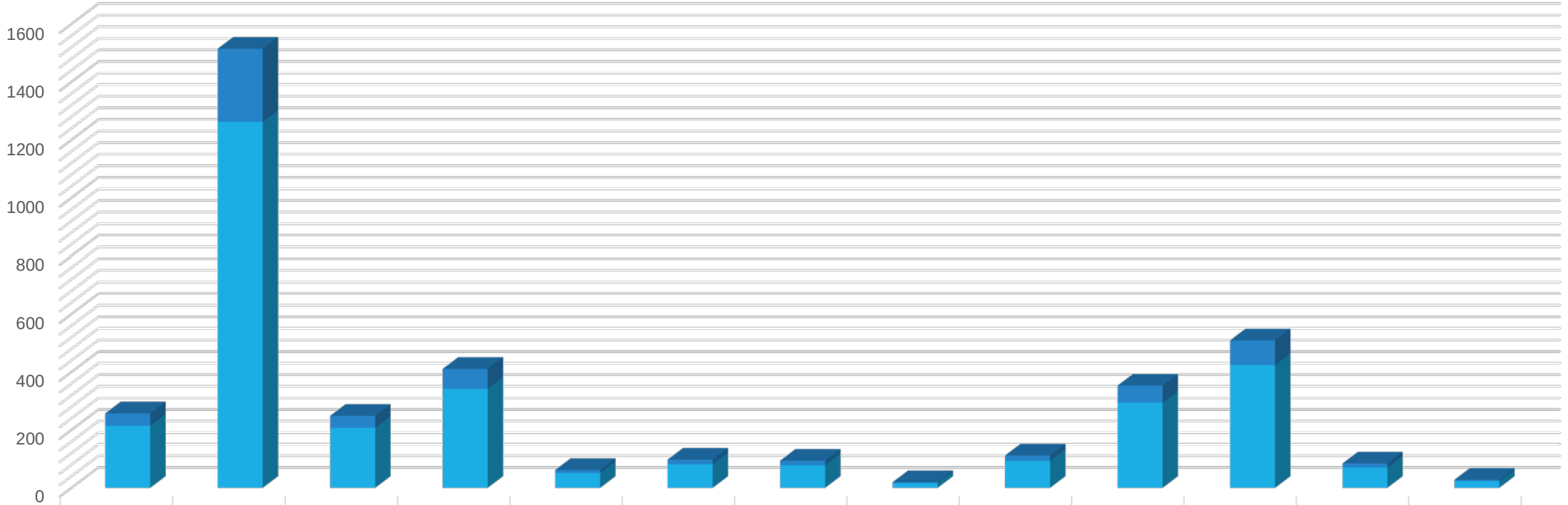


DUKE REGION BED AVAILABILITY AS REPORTED IN NCSMARTT

SURGE CAPACITY:

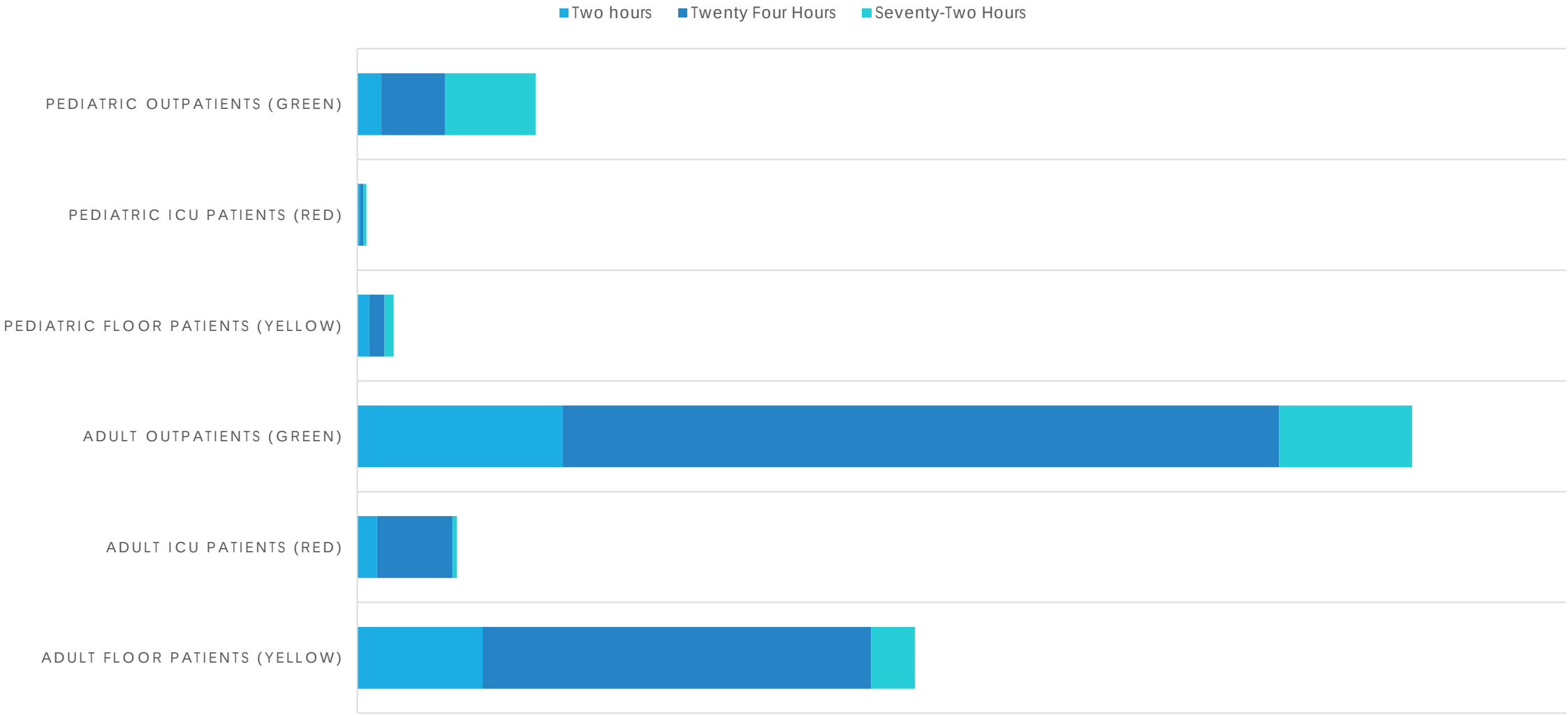
"The number of **adequately** staffed beds
that can be provided in addition to
the normal demand within 2 hours of an incident"

Minimum Regional Surge Capacity (20%) By Specialty Area



	Emergency Department	Adult Floor	Adult ICU	Isolation Capable	Neonatal	Nursery beds	Pediatric Floor	Pediatric ICU	Operating rooms beds	Long Term/ Rehab	Pysch Adult Beds	Psych Pediatric Beds	Morgue Capacity
Surge	42.8	252.4	41.4	68.4	10.2	16.2	15.6	3.2	18.6	58.8	84.8	14	4.6
Current	214	1262	207	342	51	81	78	16	93	294	424	70	23

SURGE CAPACITY BY TIME AS REPORTED IN NCSMARTT



	Adult Floor Patients (Yellow)	Adult ICU Patients (Red)	Adult Outpatients (Green)	Pediatric Floor Patients (Yellow)	Pediatric ICU Patients (Red)	Pediatric Outpatients (Green)
Two hours	83	13	136	8	2	16
Twenty Four Hours	257	50	474	10	2	42
Seventy-Two Hours	29	3	88	6	2	60

Identifying Improvements

Medical Surge Performance Measures

- **PM7:** Percent of hospitals with an emergency Department (ED) recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies.
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Discussion Questions

1. What is the process to gather and report facility/agency information to the Coalitions?
2. What systems are used to report the information?
3. How does this process differ for hospitals vs. non-hospital healthcare partners?
4. What is the expectation?
5. What is the role of the Coalition to support this process?
6. What does the Coalition do with the information? How do they share the results?
7. How does the Coalition move forward from here?

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Thank You!

Will Moorhead

President and Owner

WillM@AllClearEMG.com

Jenny Schmitz

Director of Healthcare Preparedness

JennyS@AllClearEMG.com

ALL CLEAR
EMERGENCY MANAGEMENT GROUP