

March 2, 2007

Application for the AMA-CDC National Congress

1. **CATEGORY:** Alternative Care Sites (ACS)

2. **COMMUNITY DESCRIPTION**

a. Describe your community:

The City of Danbury, where Danbury Hospital is located, is surrounded by 10 relatively small towns, which comprise the Housatonic Valley, which is located in the southwestern part of Connecticut (I have included attached a map of the planning region with the hospitals identified).

b. Describe your state and local public health infrastructure

Connecticut is a small state with a population of approximately 3.5 million people, with an approximately 650,000 pediatric population. Not having a county government, CT consists of 169 municipalities and two tribal nations. Currently there are approximately 42 full-time health departments, while the rest are part time health departments. The CT Dept of Public Health has an Office of Local Health Administration, which is the Commissioner's direct link to the local health directors. For the last 5 plus years the local health partners have been meeting at the "regional planning level", originally starting out as ten (10) public health preparedness planning regions, which are now folding into five (5) planning regions (see attached map of the 5 planning regions)

c. Describe your current health care delivery system.

Connecticut's healthcare system consists of 31 acute care hospitals, and one Veteran's Administration Hospital located in West Haven. The State also has 13 Federally Qualified Community Health Centers, and 65 School-based Health Centers. Other healthcare system partners include Emergency Medical Services, local medical Reserve Corps units, which are currently in the process of developing a Strategic Plan, and a Metropolitan Medical Response System (MMRS) in the City of Hartford. For the purposes of preparedness planning the State is split into five (5) Dept of Emergency Management and Homeland Security (DEMHS) planning regions. All the healthcare system partners are currently participants in the HRSA National Bioterrorism Hospital Preparedness Program, and are recipients of its Cooperative Agreement funds.

3. **PLANNING PROCESS**

a. How has your planning process been organized and coordinated?

Our planning process in the greater Housatonic Valley is organized around the collaborative relationships between the local health directors. Two years ago, the local hospitals were brought into this group as a key stakeholder in the emergency preparedness effort. Our planning group continues to meet on a monthly basis for two hours.

b. Describe the community members involved in your planning process.

Representatives from each local town's health department (10 towns), two hospitals, local American Red Cross chapter, Connecticut Department of Public Health, Connecticut Association of Directors of Health, Regional state epidemiologist, Regional DEMHS planner, Emergency Planning consultant

c. What specific barriers to joint planning did you face and how did you overcome them?

One barrier that we continue to struggle with is regular and consistent participation by all key stakeholders - hospitals. Emergency planning is traditionally captured as a proactive process and many of our partners find themselves working in a reactive mode, acutely taking them away from the planning table. Initially, getting each group or discipline to embrace the attendance of other groups at the planning table was an obstacle. The hospitals had to take an active role in this and reach out to a few of the health directors to lobby on our behalf. After consistent and regular attendance at the meetings, all participants were able to see the value of the newly formed relationships.

d. Problems or issues you identified as gaps in your community preparedness planning, and your strategy to close the gap.

One issue that was identified is the lack of computer literacy using some of the advanced software tools for our project. This became a labor intensive step for the hospital planner, requiring extensive meetings to review the use of the tool and step-by-step tutorials in completing the ACS matrix. In most cases, the local health directors were tasked to complete the matrix by hand and then submit for the hospital planner to enter into the database. Another issue encountered was that of public/private concern. Questions were raised as to the intent, use and publicity of the completed matrices. Some health directors did not feel qualified to submit quantitative answers on their matrix which could be viewed as derogatory or potential defaming to private business' in terms of how their locations were rated. The hospital planner met several times with the local health directors to assure them this was not a public document but merely an internal draft tool to prioritize the sites based on available infrastructure for use as an ACS. The last issue to overcome was regular turnover of personnel in the planning process. While most health departments have consistent staff, a few partners have experienced staff attrition; turnover and lay-offs setting back the planning process as new staff is identified trained and brought into the collaborative process. The overall solution to all these issues is: time, effort, energy and having a small task force that meets regularly to keep the energy alive to drive the process.

4. NARRATIVE

a. Why this topic was a priority in your community.

The identification of potential alternate care sites is a priority in ALL communities across the country. A truly catastrophic disaster or emergency, pandemic influenza, category 4-5 hurricane, high impact mass casualty incident or other, will result in a surge of patients on local hospitals. On a good day, most hospitals in our community have a workable surge capacity of approximately 10% of their total beds (ex. 300 bed hospital may have

up to 30 available beds usually including ED and PACU as expansion areas). In a catastrophic disaster, this just-in-time surge capacity will not come close to addressing the real health care needs of impacted victims. While efforts to improve the hospitals internal surge capacity continue, we MUST begin to address how the community's / local jurisdictions will assist in decompressing the volume overload experienced by the hospitals in these situations.

b. What your approach was and why you believe this to be innovative or exemplary.

We see the collaborative relationship between the hospitals and our local health directors as a starting point to address this issue. The problem of surge capacity is divided into seven focus areas: Facilities, Supplies, Staffing, Safety & Security, Clinical Requirements, Transportation and Communications. We decided to begin by addressing the facilities piece and set out to find a tool to quantitatively assess the various options for alternate care sites in our surrounding towns. We looked at several lessons learned from the Hurricane Katrina experience (Dr. P.K. Karlton's talk on the "Battle for New Orleans" September 2005 Yale-New Haven International Congress on Emergency Preparedness & Disaster Response, Lessons Learned Information Sharing (www.LLIS.gov), DHHS – Agency for Healthcare Research and Quality – Rocky Mountain Regional Care Model for Bioterrorist Events: Locate Alternate Care Sites During an Emergency www.ahrq.gov/research/altsites/alttoolmatx.htm). We started with the AHRQ tool and reworked the matrix into a quantifiable tool which will identify, in priority order, which types of sites are the best in the community and what degree of infrastructure exists in each site. The overarching concept here was to NOT reinvent the wheel, rather make the wheel roll smoother and faster than it currently does (see attached revised tool, based on the AHRQ tool).

Because it has proven to be a successful process in this one planning region as the State's Hospital preparedness Program Coordinator I have asked Andy and his local health team if they could do a presentation at the other four DEMHS region ESF-8 meetings, and to answer questions if any of the local had any. They agreed, and have begun this process at the time of this application. We look forward to sharing the outcomes of this best practice with all of you when it has been completed

c. Outcomes achieved through this approach and how you have documented these outcomes.

To date we have completed the ACS matrix for all ten of the Housatonic Valley towns. Each matrix prioritizes the sites within each town pointing us in the direction for next steps in the project. We will identify at least one best site in each town, separate from the community identified shelter and POD site, meet with the owners/managers for each site to complete an onsite survey assessment and discuss memorandums of agreement for use during an actual emergency. The most basic result from the project to date is the cementing of relationships between the local health departments and the local hospitals emergency planning partners. The completed matrices, MOA's and further work on the other six surge capacity areas will be the template for regional surge capacity in the Housatonic Valley Region.

d. Unique or particularly successful partnerships that contributed to your success.

Ongoing planning relationships with the local health directors, State Department of Public Health (DPH), State Department of Emergency Management and Homeland Security (DEMHS), American Red Cross, Yale-New Haven Center for Emergency Preparedness & Disaster Response all contribute to the current and future success of the project.

e. Advise for other planners

Start now! Build relationships with all key stakeholders over time. Be diplomatic – do not force your agenda, rather, let everyone see that they have and own a piece of this. Stay the course and develop/foster a small group of champions for your cause.

When something works well in one of your awardee-defined regions, attempt to replicate the process in all the others. Local Health Directors, Emergency Planners, and hospitals will be apt to listen more closely when one of their own relates how they went about the process, as opposed to the State Coordinator relaying the information. As Andy, Donna and Laura go from Region to Region to present their experiences at the ESF-8 meetings you really notice the appreciation the hospitals and health directors have for their counterparts in the other regions that must do the same planning.

5. CONTACT INFORMATION

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