Where the Rubber Meets the Road:
Enabling Non-Traditional Partners in Pandemic Influenza Planning

1) CATEGORIES: Medical Surge Capacity, Community Mitigation Strategies, Alternative health care sites

2) COMMUNITY DESCRIPTION: (please limit to 2 pages):

a) Describe your community.

The State of Georgia has a population of 9,363,941. Its 159 counties range in size from Fulton County with a population of 816,006, to Taliaferro County with a population of only 2,077. Thirty-six percent of the state's population lives in the 5-county Atlanta metropolitan area.

Hartsfield-Jackson Atlanta International Airport is the busiest airport in the world. In 2006, 84,846,639 passengers passed through this airport. More than 8 million of these were international travelers. Its role as a transportation hub puts Georgia on the front lines of pandemic influenza readiness and response.

Atlanta is also home to the Centers for Disease Control and Prevention (CDC). Atlanta's hospitals have collaborated with CDC to ensure that they are prepared to address the needs of CDC employees should an incident occur at CDC facilities.

b) Describe your state and local public health infrastructure

The Georgia Division of Public Health (GDPH) is the lead agency entrusted by the people of the State of Georgia with the ultimate responsibility for the health of communities and the entire population. At the state level, GDPH is divided into numerous branches, sections, programs and offices. Responsibility for emergency preparedness planning rests with the Office of Preparedness (OP) within GDPH.

GDPH is part of a larger state agency, the Georgia Department of Human Resources (DHR). At the local level, GDPH functions via 18 health districts and 159 county health departments.

c) Describe your current health care delivery system

Georgia has 150 acute care hospitals, ranging in size from Grady Hospital in Atlanta with 953 licensed beds to Charlton Memorial Hospital in Folkston with 15 beds. Thirty-five (23%) of the states hospitals are designated Critical Access Hospitals. Hospitals with 100 beds or fewer account for 58% of the state's hospitals (87 hospitals). Thirty-six percent of the hospital beds in the state are in the 5-county Atlanta metro area.

Thirteen Regional Coordinating Hospitals have been designated to coordinate resource movements and patient flow among inpatient facilities, outpatient facilities, and home care during an event. We have also designated a Pediatric Specialty Coordinating Hospital that coordinates pediatric care statewide. We expect to designate a Burn Specialty Coordinating Hospital in the near future.

Georgia has 276 licensed EMS services, 21 federally qualified community health centers (CHCs), 372 long term care facilities, and 1500 personal care homes.

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3) PLANNING PROCESS (please limit to 1 page):

Organization and coordination   The Georgia Division of Public Health (GDPH) provides an operational level framework to facilitate local community-based planning. The framework is described in planning kits that also provide specific guidance on how to plan. District and county public health staff communicate the framework through district and county pandemic flu summits. County nurse managers serve as liaisons to the County Pandemic Influenza Planning Committees. District Emergency Coordinators oversee development of health care surge capacity plans. County and district public health staff provide feedback on the process to GDPH so that the improvements in the process and the planning materials can be made. GDPH also collects and monitors the data generated during the process.

Community members   County Pandemic Influenza Planning Committees (CPIPCs) have ten task forces covering all segments of the community. The ten community segments are Government, Public Health, Health Care System, Media, Business, Schools, Transportation, Volunteer/Service Organizations, Faith-Based Organizations, and the General Public. Like organizations work together on these Segment Task Forces to develop a pandemic flu plan for their segment. A Segment Task Force Workplan and Worksheets are included in the County Pandemic Influenza Planning Kit to assist them.

The process has been built on existing organizations and relationships in the following ways:

- County nurse managers are key members of their communities, responsible for providing basic health services to many residents. Their role as public health's liaison to the CPIPCs puts a local face on the pandemic planning framework provided by GDPH.
- Local leaders in each segment in each community serve on Segment Task Forces and work with their colleagues to develop segment pandemic plans. The CPIPCs use these segment plans to create community-wide plans.
- Health care providers began surge capacity planning work under the National Hospital Bioterrorism Preparedness Program. This surge capacity planning work is now being extended and linked to the efforts of the broader community through the Health Care Segment Task Forces.
- Emergency preparedness staff in each of Georgia's 18 public health districts are responsible for supporting the planning of the health care segment in each county by assisting with the surge capacity planning of individual providers, and by developing district-wide surge capacity plans.
- Under contract to GDPH, the Georgia Hospital Association has been instrumental in coordinating the emergency preparedness efforts of hospitals through the statewide Mutual Aid Group and Regional Coordinating Hospital system.
- GDPH works with the Georgia Emergency Management Agency (GEMA) to ensure that the efforts of the public health and emergency management communities are coordinated.

Barriers   The initial reaction of Local Emergency Management Agencies (LEMAs) to the initiation of pandemic influenza planning by public health was to view it as an intrusion on their authority and responsibility for developing and maintaining Local Emergency Operations Plans (LEOPs). Pandemic influenza summits were held at the district and county level, at which public health reassured local emergency managers that the goal was to develop a pandemic flu annex to existing LEOPs.

Another challenge was to engage and motivate community organizations that are not typically involved in emergency preparedness planning. The pandemic flu summits also addressed this need and our planning kits provide practical, hands-on tools to guide the efforts of organizations that don't know where to start.

Problems or issues Our success in engaging new partners in the pandemic flu planning process has left us with a new problem: We have no easy way to efficiently track the resources offered by these new partners. We are developing a system that will not only include a database to store this information, but will also include communications capability to provide the means to activate these resources when necessary.

4) NARRATIVE: (please limit to 3 pages):

Why a priority?

> Any local government that fails to prepare expecting the federal or state government to bail them out will be tragically wrong.
>
> \- Michael Leavitt
> Secretary of Health & Human Services

Existing local Emergency Operations Plans are built on the premise that outside help will be available. Taking Secretary Leavitt's challenge to heart, we recognized that we had a need in every community to identify every resource available, not just those traditionally included in emergency plans, and to develop a cohesive plan using those resources. We must be able to fully mobilize every resource available in our communities.

Nature of the Innovation

The Georgia Division of Public Health (GDPH) provides an ***operational level*** framework to facilitate local planning. Materials from many other organizations identify *What* needs to be done in order to plan surge capacity or prepare for a pandemic. Our workbook-style planning kits show community planning bodies and individual organizations *How* to go about the necessary planning. There are three types of planning kits:

- Surge capacity planning for existing health care providers,
- Kits for planning temporary health care facilities, and
- Community-based pandemic influenza planning kits

Extending the framework to each segment assists local leaders in developing, not just general plans for their communities, but plans in which all of the segments in the community have addressed their specific needs, and identified the specific ways in which they can assist their community. Because a common framework is being used statewide, it is possible to coordinate efforts across communities. Using a workbook format allows users to document their efforts with a minimal paperwork burden.

An important characteristic of the planning process is its iterative nature. We work to maintain a continuous feedback loop so that we are aware of how well planning kits are serving their intended purpose. We proactively call users of planning kits to get their feedback.

Because planning on the scale necessary for a pandemic has rarely, if ever, been undertaken, we find that user feedback is often non-specific. They know they're missing something, but they're

not sure what. Planning kit development has involved taking vague statements about difficulties encountered and using them to develop additions to the tools to address those issues.

Counties across Georgia vary widely in the level of expertise and experience in emergency preparedness planning that their leaders can bring to the pandemic influenza planning table. Capturing the experience of the frontrunners and using it to improve planning materials is key to continually improving the planning process and the plans that result from it.

Application of the framework to surge capacity planning has allowed us to develop extensive, concrete surge capacity, well beyond HRSA requirements. *We believe we are the most populous state that can claim 100% participation by its hospitals in the HRSA planning process, and the only state to exceed the HRSA benchmark for surge capacity by such a wide margin* (see Outcomes section below).

Outcomes Achieved

The planning kit for CPIPCs defines their role as: Identify, Communicate, Plan, and Coordinate:

- ***Identify*** all of the organizations in each segment in the community.
- Determine the best way to ***communicate*** with all of these organizations and develop a communication plan, to be used during planning activities and during the actual pandemic.
- Help each organization in each segment ***plan*** how it will prepare and what role it will play during the actual pandemic.
- ***Coordinate*** the plans of all the organizations in each segment to maximize the effectiveness of the community's planning and to create a pandemic flu plan for your community.

The 159 counties in Georgia have achieved these goals to varying degrees. The most advanced have completed their plans, exercised them, and revised them based on the outcome of the exercises. The experience of these counties is being used to improve planning materials to assist other counties in developing and testing their pandemic plans.

We are in the process of surveying our counties to document the current status of planning in each county. We will also be collecting data that will be used to populate our database of local community resources.

Because planning for health care surge capacity began before pandemic influenza planning, our best documented outcomes are in this area. To facilitate hospital surge capacity planning, we defined three Internal Surge Capacity (ISC) planning areas and asked hospitals to quantify the number of beds they had in each category. **All** of the state's 150 acute care hospitals completed the Surge Capacity Planning Kit for Hospitals, reporting a total of:

- 2,276 ISC1 beds (equipped, but NOT staffed),
- 4,357 ISC2 beds (in day treatment units), and
- 6,952 ISC3 beds (spaces in hallways, classrooms).

These 13,585 beds represent a surge capacity of 77% over and above the approximately 17,642 normally equipped and staffed beds in Georgia's acute care hospitals.

Caches of supplies and pharmaceuticals have been placed in individual hospitals to support the ISC1 and ISC2 capacity they reported. Public Health District caches to support ISC3 beds include 7,000 disaster hospital beds, other equipment, supplies, and pharmaceuticals. The ISC

beds, and the caches to support them, give Georgia a surge capacity of 332% of the HRSA requirement.

An annual update tool was developed to continue the planning begun in the surge capacity planning kit. The Annual Statement of Capability and Needs was distributed to hospitals to confirm that they had modified their emergency management plans to include the surge capacity planning categories, and trained and exercised their staff in their activation. It also queries hospitals on specific other capabilities, such as isolation, ventilators, and communications.

Successful Partnerships

Working relationships have been built between public health staff and the individual health care providers in their jurisdictions. The Georgia Hospital Association (GHA) has been a key partner in building those relationships. GHA developed a Mutual Aid Compact which has been executed by all of the hospitals in Georgia, and they coordinate quarterly Mutual Aid Group meetings with two-thirds or more of the hospitals attending each meeting. They also developed the system of Regional Coordinating Hospitals that coordinate resource movements and patient flow among inpatient facilities, outpatient facilities, and home care. The RCHs are funded by the GDPH to develop a Regional Coordinating Hospital Operations Center (RCHOC) for their region when the surge capacity plan is activated. As we move into planning with other hospital community organizations, we are similarly involving their professional associations.

Individual counties have found success building partnerships with organizations they have long sought to involve in public health projects. The relationships built during pandemic influenza planning will hopefully endure and be extended into other initiatives to benefit local communities.

Advice

Achieving full participation in a process to prepare for an event that some people believe will never happen requires persistence and the utilization of existing relationships in a community.

Hospitals were contacted by district public health staff, regional coordinating hospitals, and the Georgia Hospital Association (GHA) in order to achieve a 100% return on the surge capacity planning kit. Receipt of HRSA funds is dependent on completion of the planning materials provided at each step in the process. Peer pressure is brought to bear by posting the names of delinquent hospitals on the GHA Disaster Readiness website. When necessary, hospital CEOs were notified by GDPH of the failure of their hospital to submit the materials necessary to receive their share of HRSA funds.

Engaging key community leaders helps to recruit others in the community to participate in the pandemic influenza planning process. The county nurse managers are familiar with these leaders because they are members of the community. Their involvement in the county-based pandemic influenza planning process has been a key to its success.

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