ASPR Healthcare Preparedness Program (HPP) Overview and Collaboration

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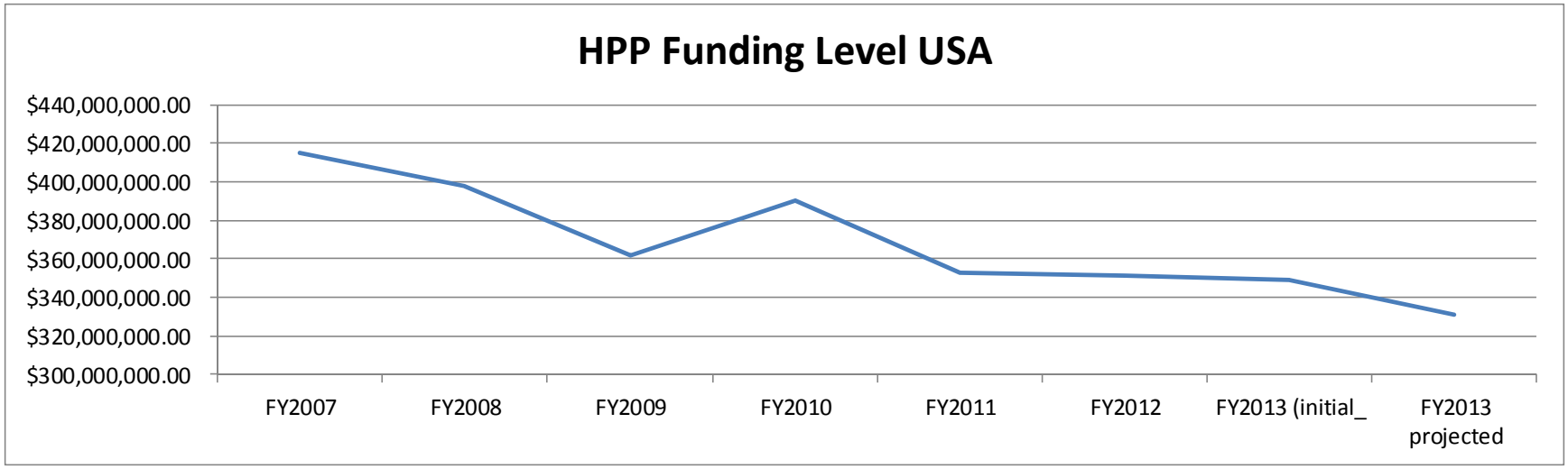
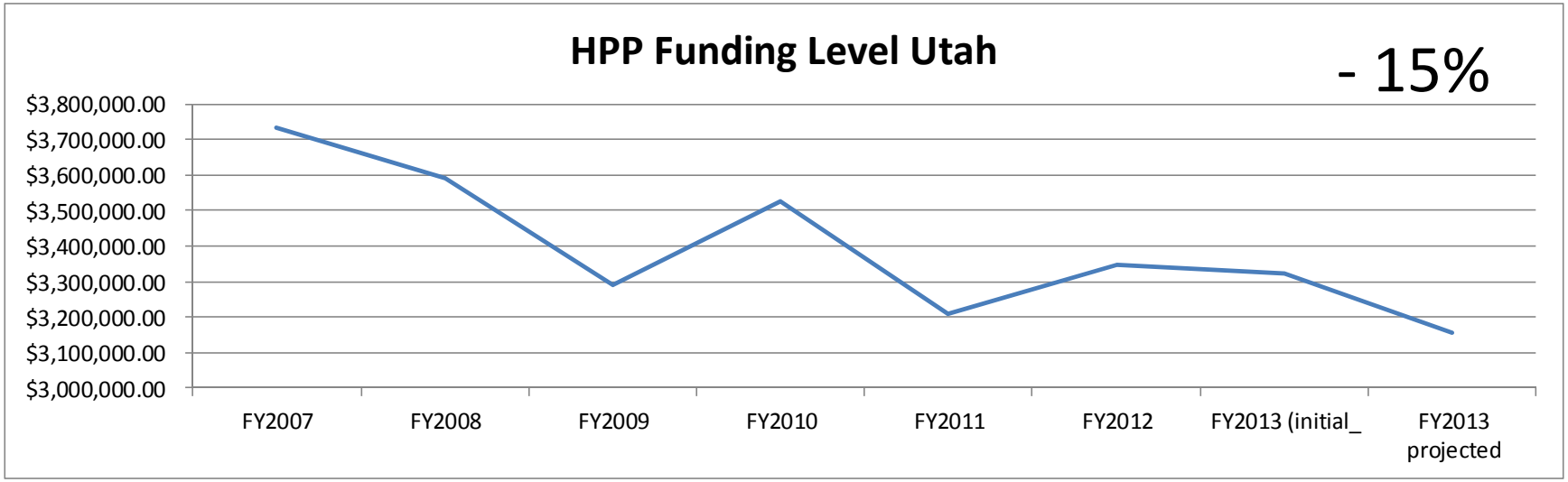
UTAH DEPARTMENT OF HEALTH

Overview

- Funding – Where are we going?
- Doing More with Less
- Medical Surge, IBA, and Regions
- 2013-14 and beyond
- Q&A

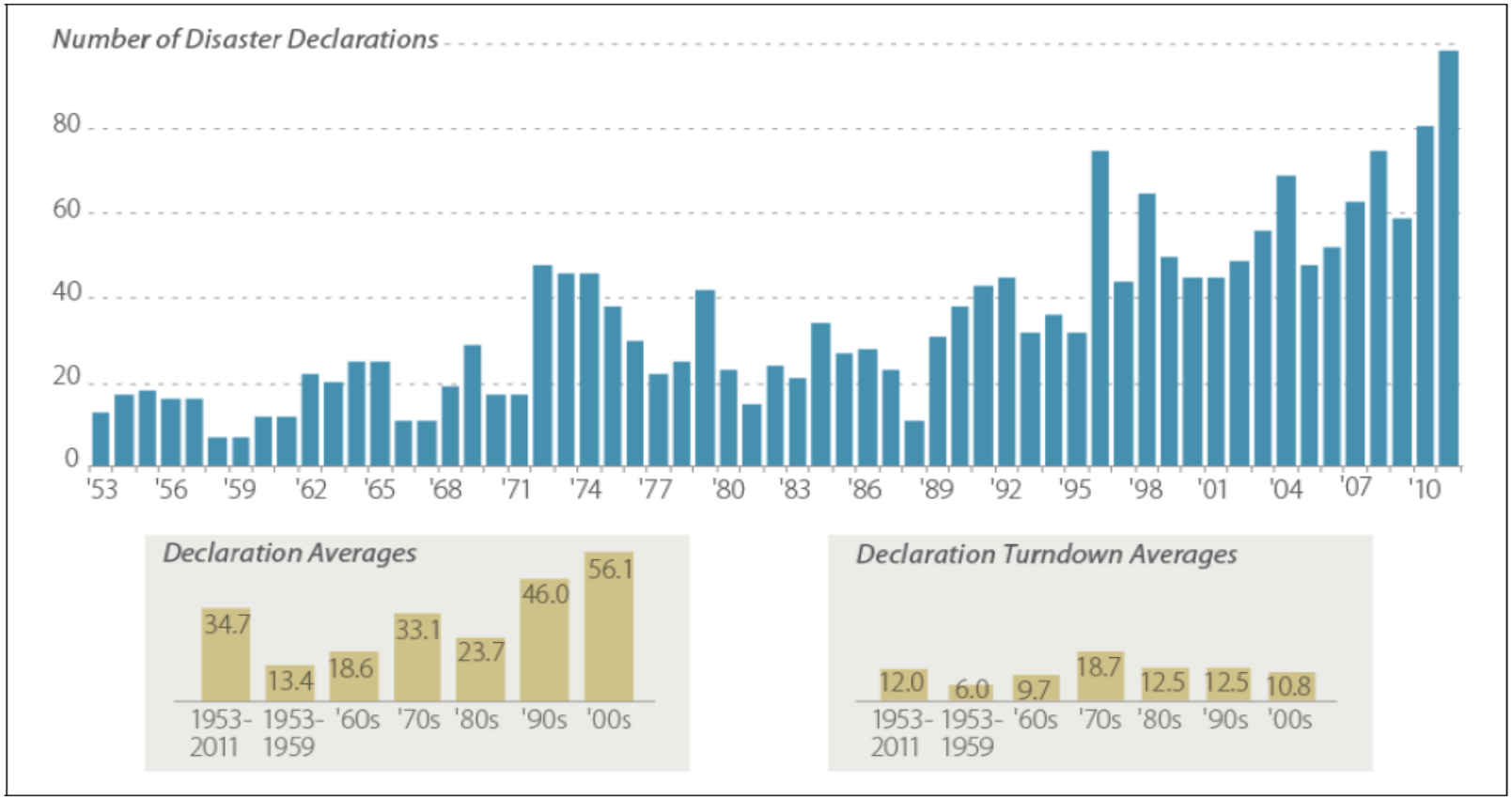
Funding Goes Down





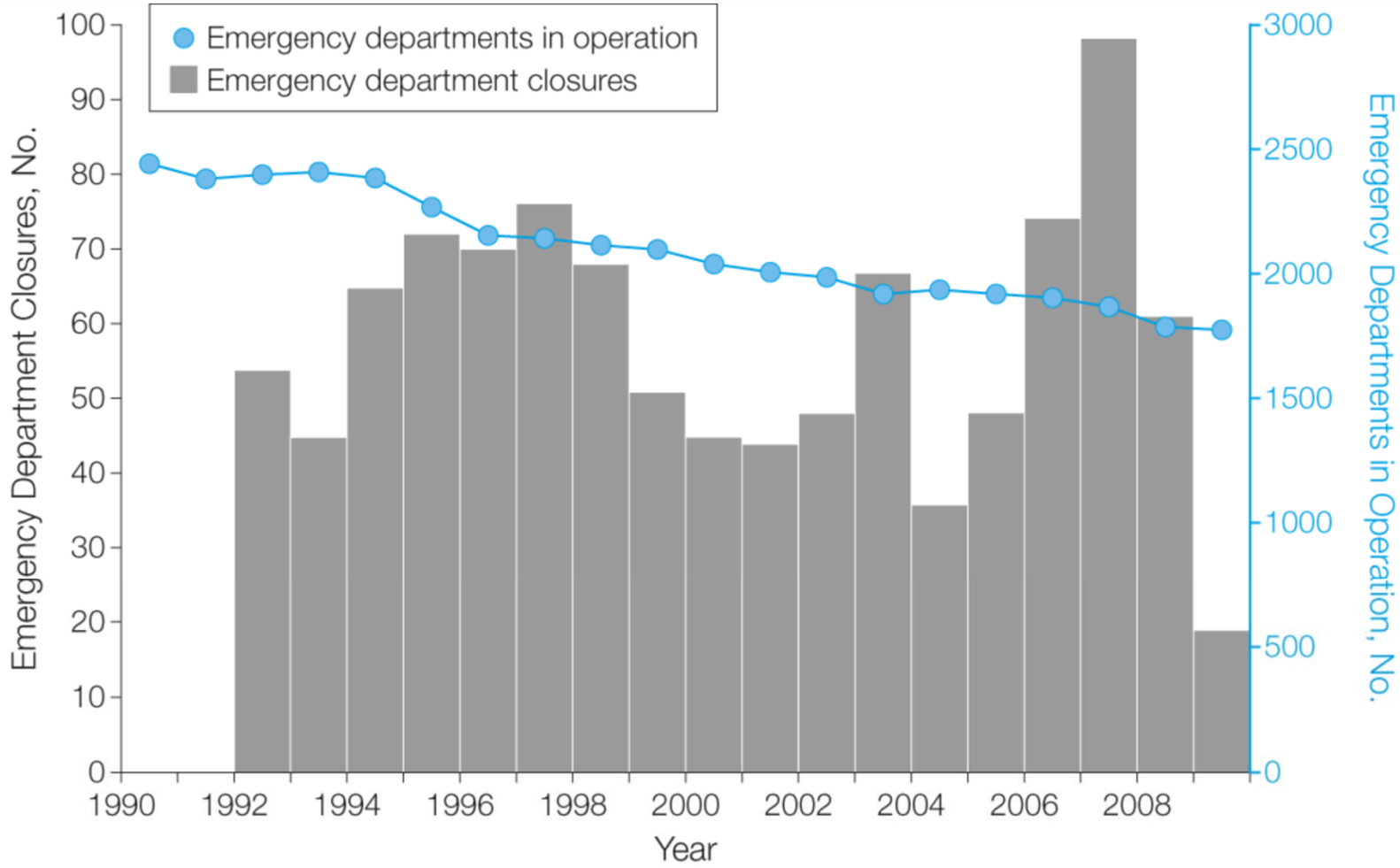
As Declarations Go Up

Figure 5. Major Disaster Declarations
1953-2011

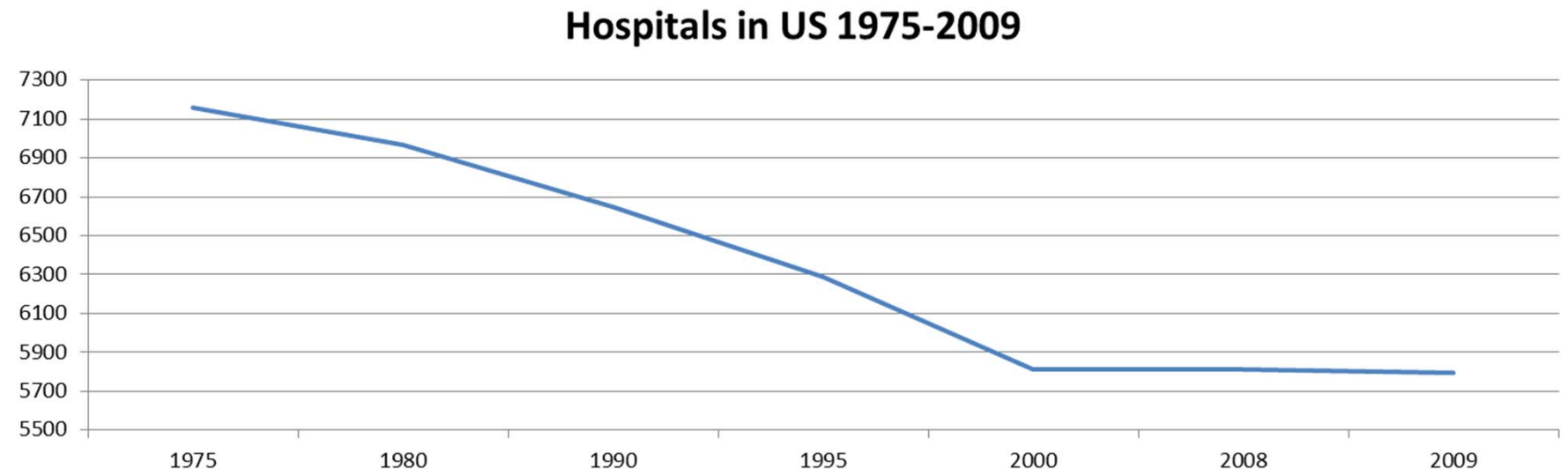


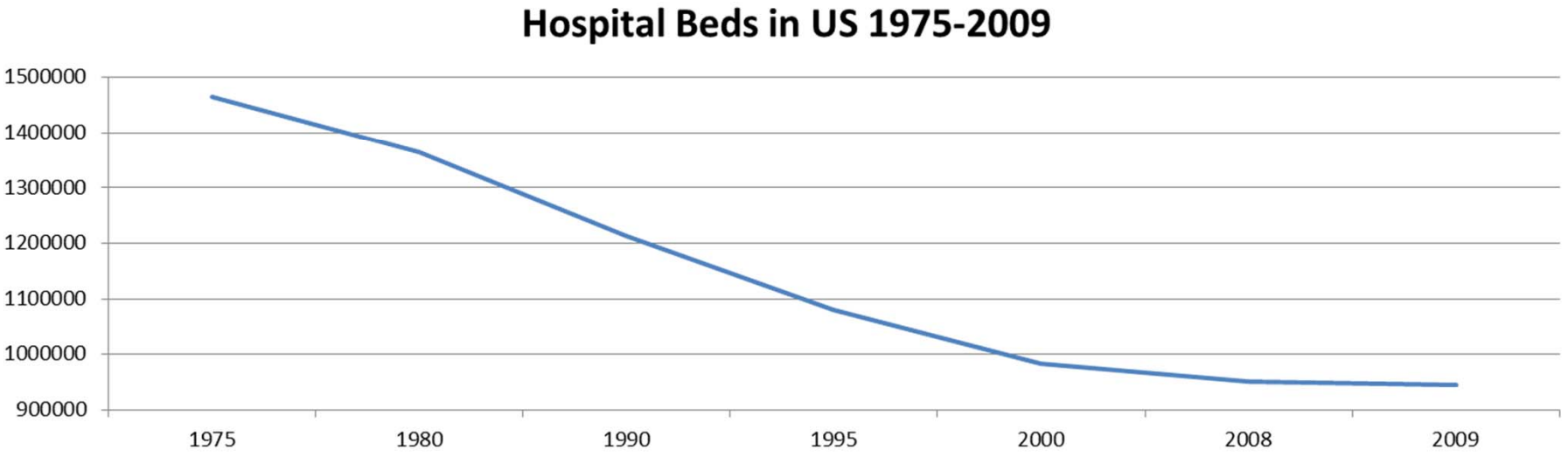
Source: CRS analysis based on data provided by FEMA.

Hospital Access Declines

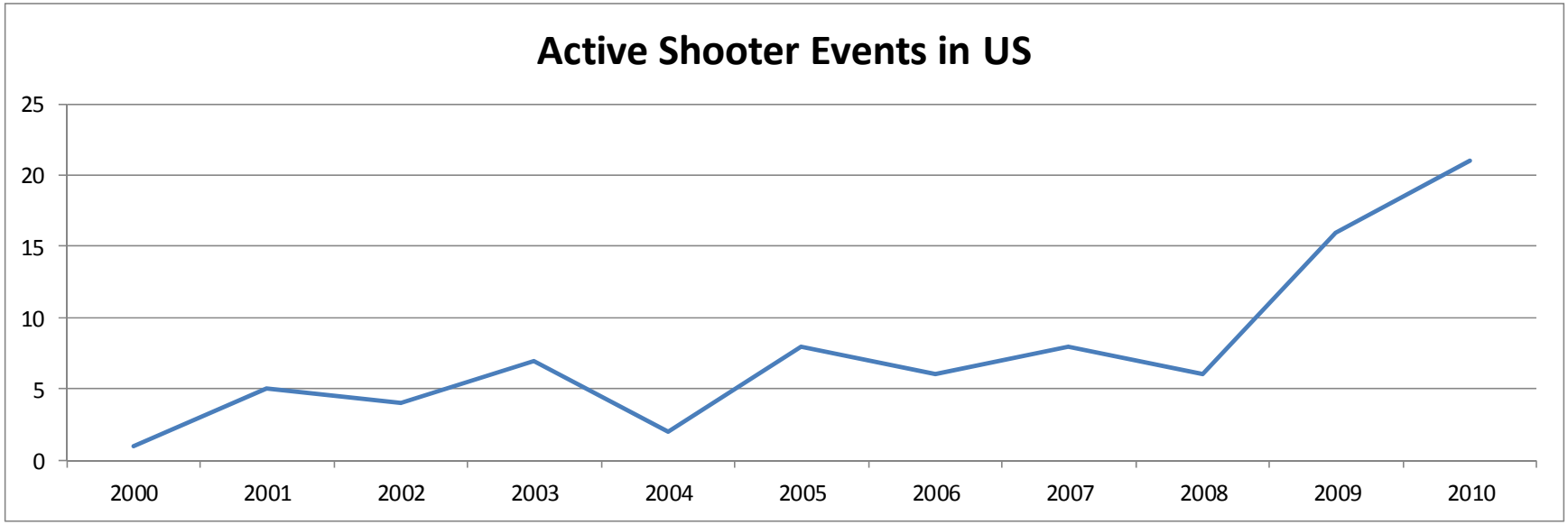


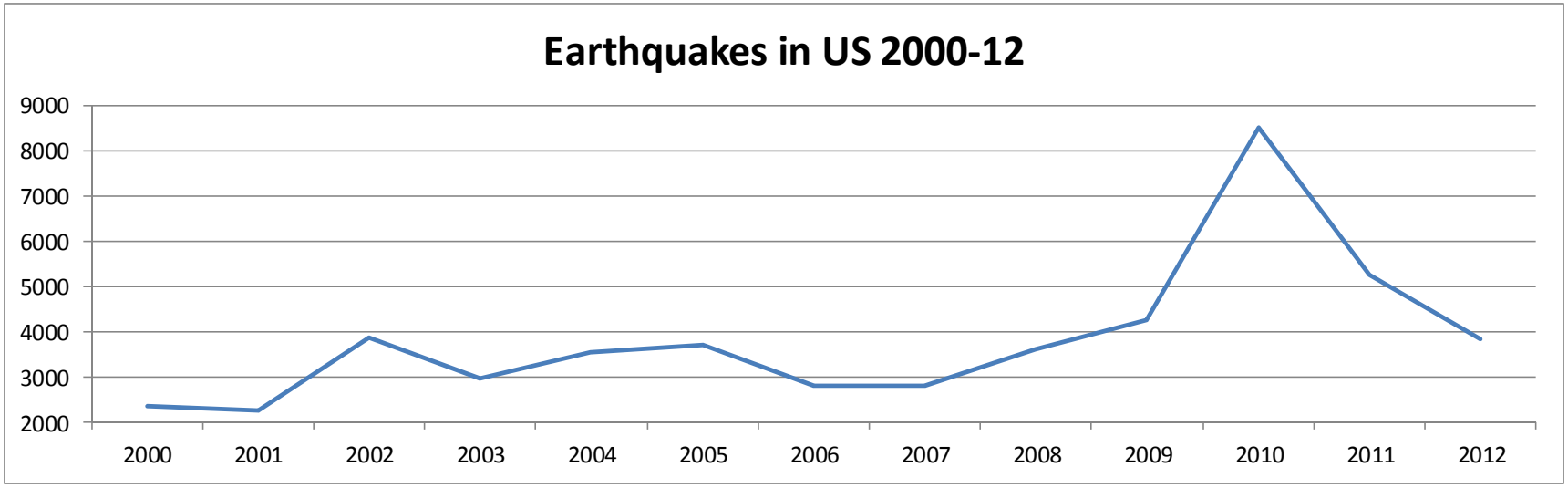
Hospital Access Declines





As Events Continue





As Events Continue

- HazMat - 2,000 hazardous chemical types, 500,000 shipments daily
- 15-state study (1990-2009, included Utah)
  - Hazardous Substances Emergency Events Surveillance Program
  - 9,000 releases of hazardous substances annually
  - 2,000 people a year impacted, 50% go to hospitals
  - 4-year period, 7,500 people required decon, and 2,643 were conducted at medical facilities
- Utah – 2009
  - 252 acute HazMat events (114 fixed, 138 transport)
  - 62 of these events generated 108 victims
  - 63% not deconned, 13% deconned at scene, 17% deconned at medical facility, 7.5% deconned at both scene and medical facility

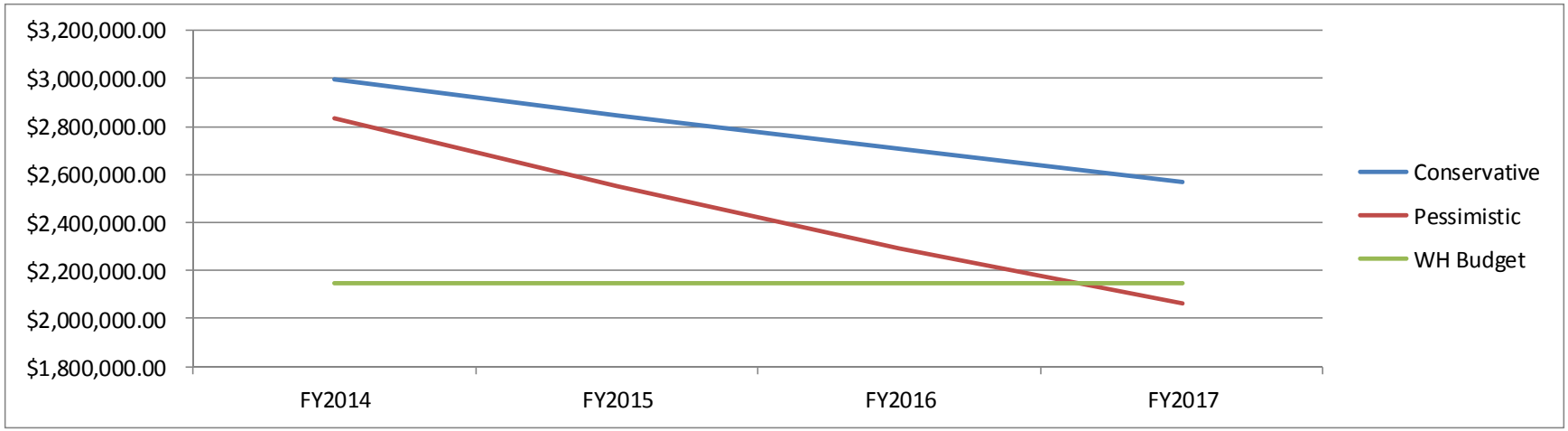
As Events Continue

- Hospital Evacuation
  - 1971-1999 – 275 documented evacuations (21/yr.)
    - Internal (59%) – fire (23%), internal HaZmat, loss of utilities, human caused threat
    - External (39%) – hurricane, earthquake, fire, flood, HazMat
    - Other (2%) – miscellaneous
  - 1994 – 33 evacuations – Northridge earthquake
    - 8 hospitals (9% of total) evacuated in LA County
    - 6 were immediate evacuations (taking from 1 to 19 hrs.)
    - Nonstructural damage cited as primary cause
      - Water damage as primary (burst pipes, sprinklers, ruptured rooftop tanks). Also noted loss of power, inability to provide medical care (no HVAC, no fire-suppression, destruction of supplies and equipment)

As Events Continue

- 2005 Katrina
  - 97 hospitals impacted, 30 evacuated
  - 22,200 workers, 5,048 beds
- 2012 Hurricane Sandy
  - 7,100 people evacuated from hospitals and nursing homes in multi-state area
  - In NYC alone, five hospitals and 30 nursing homes or adult residential facilities evacuated (6,300 people)
  - 33% (30) New Jersey hospital on generators by the morning after, 5 on generators for over 5 days

Projected Funding Summary



- Conservative – 5% decline yearly - $3.2m to $2.6m by 2017
- Pessimistic – 10% decline yearly - $3.2m to $2.1m by 2017
- White House Budget proposes 32% reduction in HPP
  - From $3.15M to $2.15M in one year, then flat.
  - Increased investment in BARDA
- For 2013-14 our initial cut will come from the Regional Equipment Cache

Funding Distribution

- Direct support to HCO – 40%
- Regions and Medical Reserve Corps – 30%
- UDOH Admin and EMS – 25%
- UDOH Information Systems – 5%

So What Does This All Mean?

- Catastrophic and significant events will continue, regardless of HPP funding level
- Conflicts with a JIT and cost reduction model
- A decrease in HPP funds available to hospitals will not change the performance standards expected by
  - OSHA - Worker protections, chem/bio hazards
  - NFPA – Fire protection, security, critical infrastructure, hazards assessment, evacuation, EOP development
  - Joint Commission – All areas of performance
  - Utah Rule for Hospitals – R432-100

So What Does This All Mean?

- The HPP program is a “drop in the bucket”
  - 0.0001% of overall National health expenditures
  - $347,000,000 of $2,500,000,000,000
  - 0.04% of total Hospital expenditures in 2010
  - $347,000,000 of $814,000,000,000
- That we must focus on scalable response systems, improve day to day care, consider financial sustainability, and sustain regional approaches to medical surge.

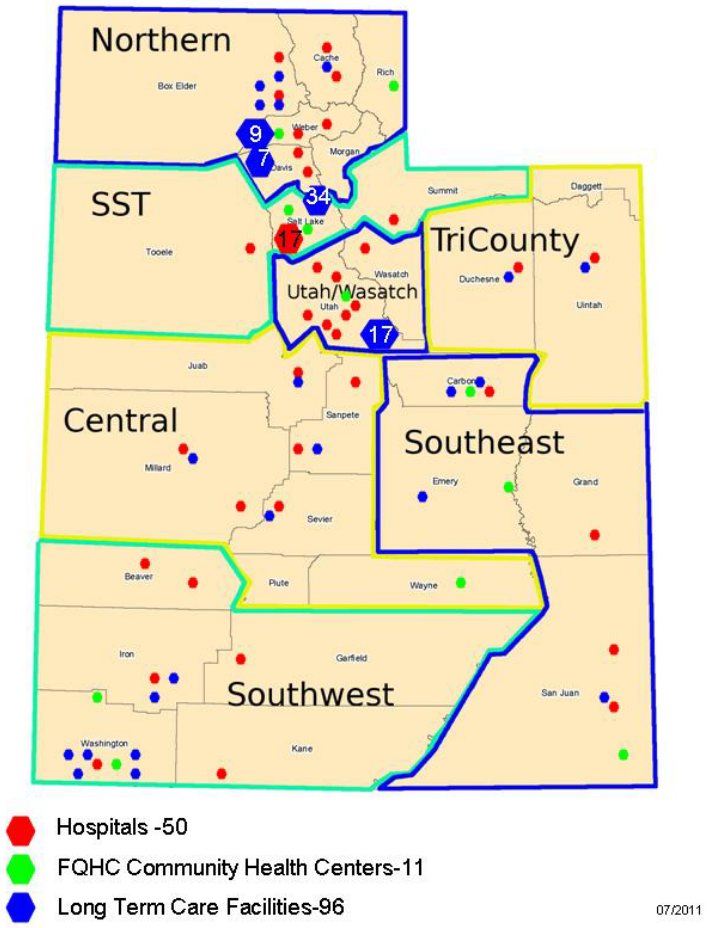
So What Does This All Mean?

- At the hospital level, critical factors include
  - Existing level of readiness
    - Active Shooter/Workplace Violence
    - Facility Evacuation/Shelter in Place
    - HazMat/Decontamination
  - Coordination with local and Regional partners
    - Law Enforcement
    - Receiving Facilities/Supply Chain Vendors
    - First Responders/Fire HazMat

So What Does This All Mean?

- Support hospital preparation for internal and rapid events that don't allow time for outside help
- Leverage the Regional Coalitions to make available for larger/extended events
  - Staffing support
  - Supply and Equipment Support
  - Communication Linkages
  - Patient Movement and Transportation
  - Local immediate bed availability/medical surge processes

Leveraging Regional Coalitions



- One goal for medical surge is to create Immediate Bed Availability
- To quickly provide higher-level care to more serious patients during a disaster with **no new space, personnel, or equipment**
- Performance Measure: The ability of Coalitions to provide no less than 20% bed availability of staffed members' beds, within 4 hours of a disaster

Immediate Bed Availability (IBA)

- Space
  - ~20% of hospital patients are discharged daily
  - Many others may also be available for discharge
- Staffing
  - Likely the key restriction for ability to care for pts.
  - Callbacks, MRC, modified work hours, plans for home health and clinics
- Build disaster preparedness into existing healthcare system – Reverse Triage

The Pillars of IBA

- Continuous Monitoring
  - Maintain operations, monitor patient acuity in real time, continually establish disaster disposition protocols
- Off-Loading
  - Use disaster protocols, increase bed turnover, discharge or transfer low-acuity patients to Coalition partners, defer elective admissions/ procedures
- On-Loading
  - Redeploy existing resources to allow for higher acuity admissions

The Pillars of IBA

- Continuous Monitoring
  - Access to real time data (beds, acuity, wait times)
  - Use existing systems (UHRMS, UNIS, POLARIS)
  - Patient tracking system
- Off-loading
  - Reverse Triage, decrease ED length of stay, transfers and discharges, in-house offloads
- On-Loading
  - Done every day in ED
  - Mass. General – 49 ED beds, 90 patients, bombing, 9 minutes to first patient, created 30 ED beds in 20 minutes

How Do We Get There?

- Continuous Monitoring
  - Real time bed availability for hospital and LTC
  - Increased use of EMS real-time data
  - Ensure Coalition communicates
- Off Loading
  - Internal protocols, training and exercises with Coalition
- On-Loading
  - Leverage existing processes that are done each day

Program Highlights 2012-13

- Recognition for our work on Regions
  - 5 conferences, TA to 6 states
- Staffing Changes
  - Michelle Hale – new HPP Coordinator
  - Julianne Ehlers – new Uintah Basin Coordinator
  - Mindy Colling – new Planner
- ICDP training for nursing and medical students
- SST Icy Hot exercise as a model to follow
  - Including engagement with National Guard HRF
- Increased partnerships from Regions

HPP Program Targets 2013-14

- Leverage Grants Advisory Committee
- Increase situational awareness/monitoring
- Enhance coordination with EMS (EMS Regions)
- Complete patient tracking system
- Increased work with Behavioral Health
- Get LTC/SNF into UHRMS bed tracking
- Finish Burn Surge Plan, initiate Pediatric Surge Plan, progress with Crisis Care Plan
- Coordinate various UDOH EOPs into one master plan

Hospital Grant Program 2013-14

- Maintain funding at existing level
- Ensure deliverables address multiple agency requirements if possible
- Leverage Regions for
  - Continuous monitoring/facility awareness
  - Increased participation in exercises by hospitals
  - Inclusion of non-hospital partners
- Improve grant processes on both ends

Hospital Grant Program 2013-14

2012-13 Deliverables	2013-14 Deliverables	What/Why?
Budget Workplan	Budget Workplan	Review/approve use of funds
4 Comms Drills (2/Phase)	2 Comms Drills (anytime)	Grantee burden
2 EOP Sections (1/Phase)	1 EOP Section TBD (anytime)	To allow group focus
Spring Survey	Spring Survey	Data needed for HPP grant
Active in Coalition	Active in Coalition	Core grant deliverable
Closeout Packet	Closeout Packet	Reimbursement Request
NIMS Compliance Plan	--	Done individually (TA)
UHRMS Compliance	--	Done individually (TA)

Improvement Plan

- Challenge #1 – Too much work at the end.
  - Expenditures begin as soon as budget is approved.
  - Allow close out to take place prior to end of project
  - Use close out packet worksheets as a running record of project activity. (Inventory, training, exercises, add NIMS, add Comms, others?)
- Challenge #2 – 750 documents for us to review.
  - Minimize single deliverables, use survey and other packets to collect needed data.

Improvement Plan

- Challenge #3 – Official forms (grant signed, FFATA, Assurances, W-9)
  - Looking at electronic systems to manage
- Challenge #4 – Lack of clarity on project
  - Conduct webinars and group technical assistance
  - Increase individual technical assistance
  - Choose Focus Areas each year?

Improvement Plan

- Challenge #5 – Limited support from hospital administration
  - Develop cost/benefit analyses to support continued participation
  - Address COOP and Recovery

- Challenge #6 - ????
- Challenge #7 - ?????

Capability Review

- Healthcare System Preparedness
  - Coalitions, Training, Exercising, At-Risk Populations, NIMS
- Recovery
  - COOP, Business Continuity, Area Recovery Plans
- EOC Coordination
  - Command centers, Regional role in EOCs, incident information sharing

Capability Review

- Fatality Management
  - Contribute to jurisdictional/Regional MF plan, MH support for hospital staff
- Information Sharing
  - Situational awareness, UHRMS, patient tracking, patient record tracking, interoperable and redundant comms
- Responder Safety and Health
  - Pharmaceutical and PPE plans and supplies

Capability Review

- Volunteer Management
  - Assess needs and roles for HCO volunteers, maintain ESAR-VHP registry, coordinate deployments

Medical Surge

- HCO coordination with EMS and 1st responders
  - Triage, transportation, patient identification, documentation, decontamination (CBRNE)
- Assist HCO with surge management
  - Clearing of beds to increase acute access
  - Immediate Bed Availability of 20% above norm
  - Additional staff and supply requesting
  - Care for unique patients (peds, burns, vent support needed, dialysis needs, chronic diseases, others)
  - Decontamination assistance to HCO
  - Local coordination of mental/behavioral health support

Medical Surge

- Develop Crisis Standards of Care (UHA)
  - Indicators, ethics, legal, scarce resources management
  - Progress made with Pandemic (H1N1), Burn Surge plan
  - Next – Pediatric surge plan, overall CSC plan with approval, training, testing, exercising
- Provide assistance to HCO with Evacuation and Sheltering in Place
  - Outbound and inbound (receiving patients)
  - Transportation beyond the curb, identification of destination locations
  - Ongoing support requests for shelter in place

Sources

- Slide 3 –http://www.phe.gov/Preparedness/planning/hpp/Pages/funding.aspx,
- Slide 4 – http://www.fas.org/sgp/crs/homesec/R42702.pdf
- Slide 5 - http://jama.jamanetwork.com/article.aspx?articleid=1161864
- Slide 6 - http://www.cdc.gov/nchs/data/hus/2011/116.pdf
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