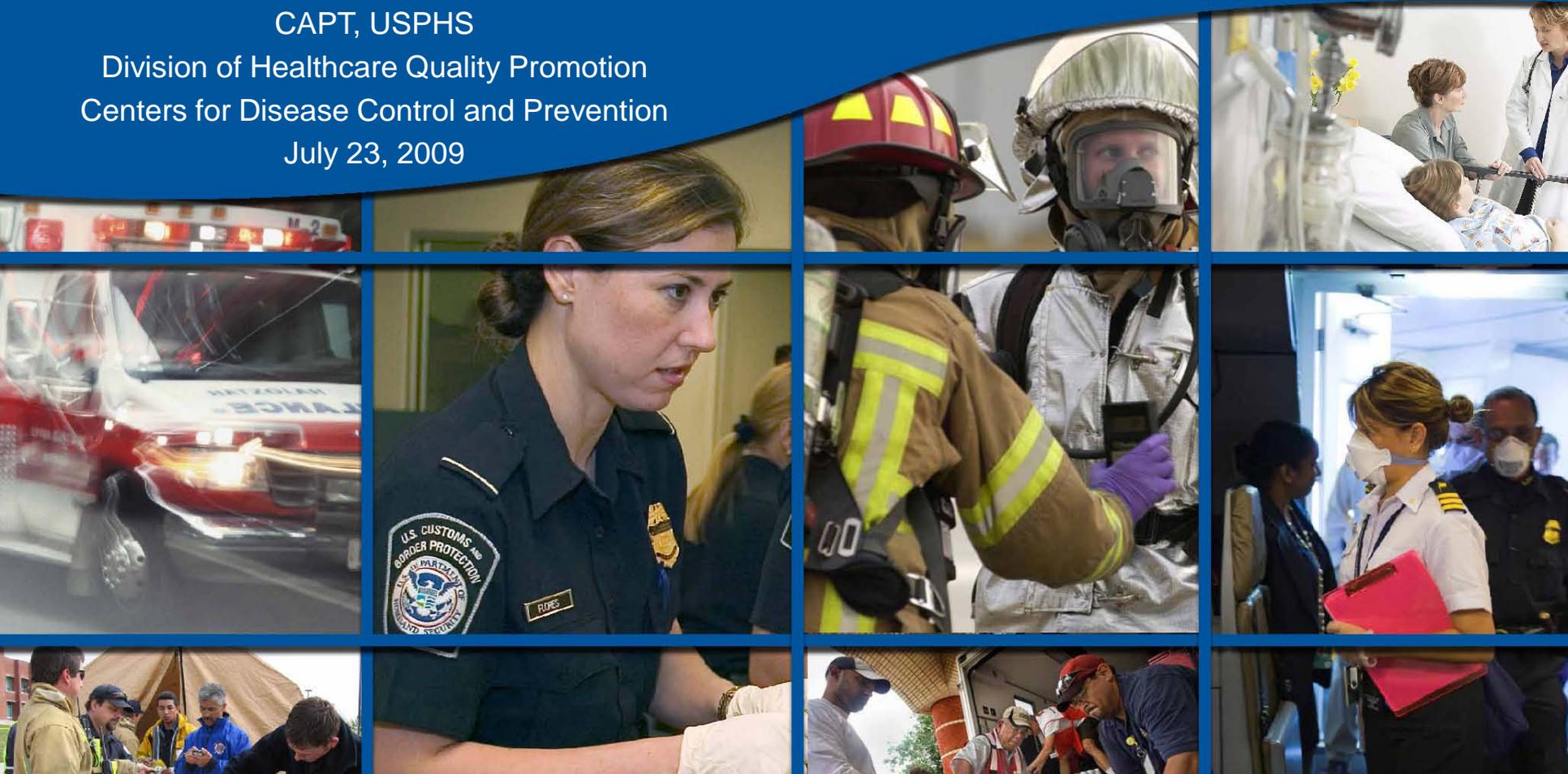


Community Partnership Workshops for Delivery of Healthcare During an Influenza Pandemic

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Overview

- Introduction to Healthcare Preparedness Activity/DHQP/CDC
- Rationale for community workshops
- Workshop activities
- Discussion break
- Lessons learned and conclusions

The findings and conclusions in this presentation are those of the author and do not necessarily represent the views of the Centers for Disease Control and Prevention/the Agency for Toxic Substances and Disease Registry



CDC/DHQP's Role in Pandemic Influenza Healthcare Preparedness Planning

- Support HHS/ASPR, lead for HC preparedness at CDC
- Coordinate with our federal partners to develop guidelines (e.g., ASPR, AHRQ, DOT, DHS)
- Emphasize innovative strategies to empower local communities
- Include all components of the healthcare sector
- Develop tools based on local requests/needs
- Identify roadblocks to preparedness as grounds for future efforts

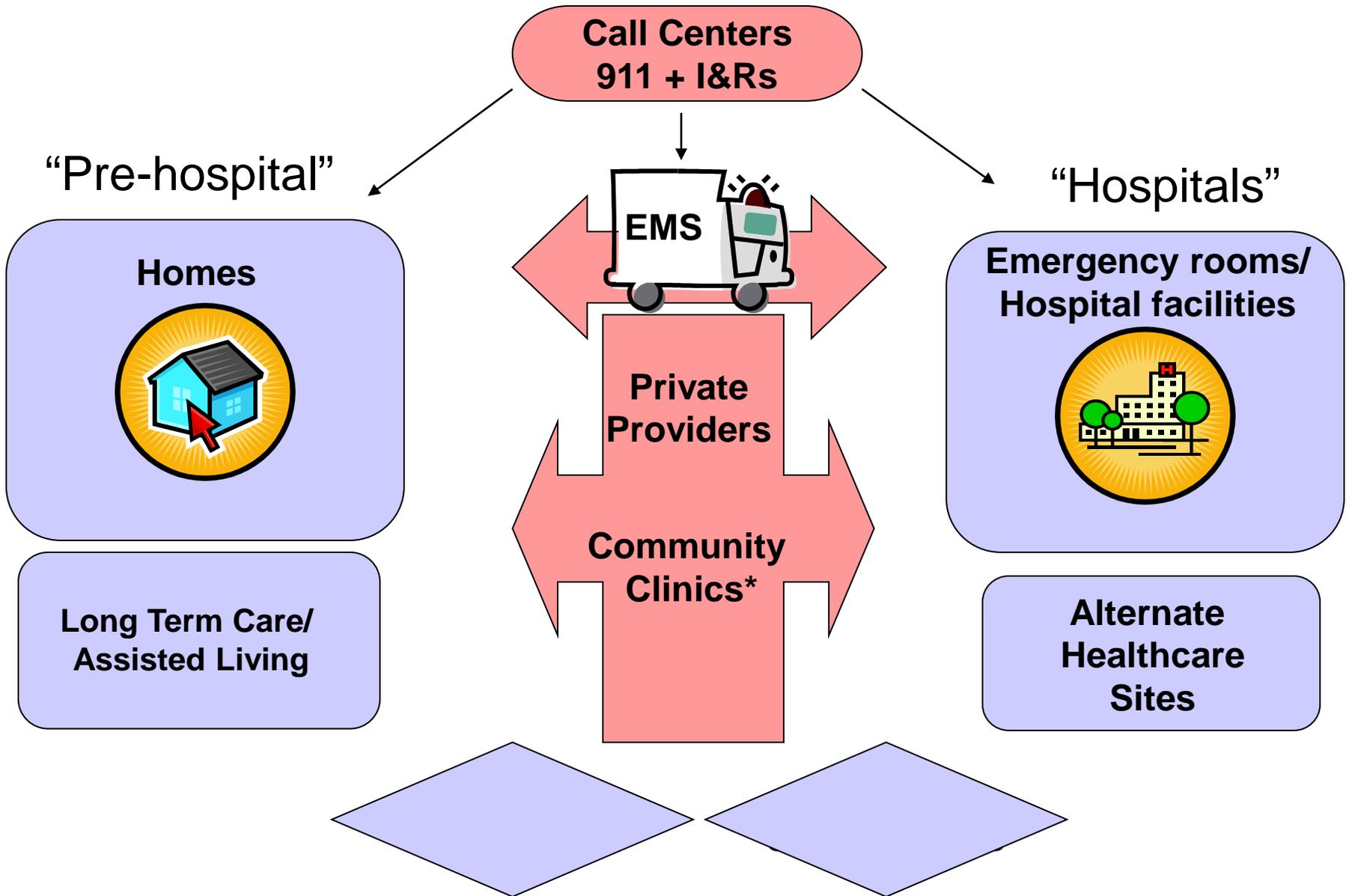


DHQP's Focus Areas

- Healthcare systems planning and implementation at the local/community level
- Triage and clinical protocols and algorithms
- Medical countermeasures and other essential material
- Situational awareness of the healthcare system and infrastructure
- CDC's response capability



Delivery of Care



*Community clinics refers to a spectrum of outpatient/private provider, rural health centers, urgent care centers, federally qualified health centers (FQHC) and FQHC-like entities

Community Workshops for Healthcare Delivery in an Influenza Pandemic

Purpose

- Develop coordinated strategies for delivering healthcare to those at home, in the community, and up to and including the emergency room
- Identify preparedness needs related to healthcare delivery among community planners and other stakeholders
- Develop a “Community Model of Healthcare Delivery” for an influenza pandemic

Community recruitment

- Issued Request for Participation (RFP) 10/07
- Engaged communities via telephone
- Four diverse communities selected as partners for 2008 workshops



Community Workshops for Healthcare Delivery in an Influenza Pandemic



2008 Activities

- Models of Healthcare Delivery
 - Mid-sized metropolitan area
 - Multi-county rural region
- Development of an Alternate Care System
 - Mid-sized metropolitan area

2009-2010 Activities

- Follow-up workshops planned for 2009/2010, large urban areas and alternate care system
- Continuing to develop tools/templates for community planners and other stakeholders



Pre-Workshop Planning

- Established a community planning team
 - Worked with ORISE and CDC to prepare agenda and activities
 - Selected and invited workshop attendees representing each community's healthcare response system
- Conducted needs assessment
 - Identified in initial RFP and through teleconferences
 - Reviewed pandemic influenza plans
 - Completed the Community Assessment Tool



Participating Sectors

- 911 and other call centers
- Emergency medical services
- Emergency departments
- Hospital administrators
- Primary care providers
- Urgent care centers and other outpatient clinics
- Home health
- Long term care
- Palliative care
- Pharmacists
- VA medical centers
- Public health
- Emergency management
- Local government
- Mortuary services
- Faith-based organizations
- Schools/school nurses
- Legal
- Public safety
- Non-profit organizations



“Pan Flu Scramble” Activity

- Bring healthcare partners and supporting organizations to the same table
- Visualize surge in ill patients that will likely accompany a moderate to severe influenza pandemic
- Identify community’s issues and chokepoints associated with patient care



Emergency Department Situation Card

Today is not a typical day!

Between 5:00 a.m. and 7:00 a.m. this morning, several of your ED staff members have called to report that they are unable to come to work - many have the flu and several others are caring for sick family members or may be contagious. Several patients arrived last night in critical condition. Staffed beds and ventilators are running low. Several transport beds (gurneys) have been set up in the halls. Your waiting rooms are full with walk-ins (self-referrals) and accompanying family members of ill persons. Many others are standing as there are no empty chairs. Many patients appear distressed and anxious - they have been waiting all night to see a doctor and many are worried they have the flu.

Due to the call-ins, one ED physician and two nurses are working the Provena ED while three ED physicians and four nurses are working the Carle ED.

At the present time, of the 26 beds for each Provena ED and Carle ED, each have two (2) ED beds open and two (2) ventilators.

**Between both EDs, you have four (4) ED beds and four (4) ventilators not being used at the present time.

You are beginning to get low on PPE.



Emergency Department Round 1

22 year-old male
temperature of 104° F
very enlarged tonsils (almost touching one another)
stridor
shortness of breath
increasing anxiety
dry cough
O₂ sat is 85% on room air
P—124, R—30, BP—140/96



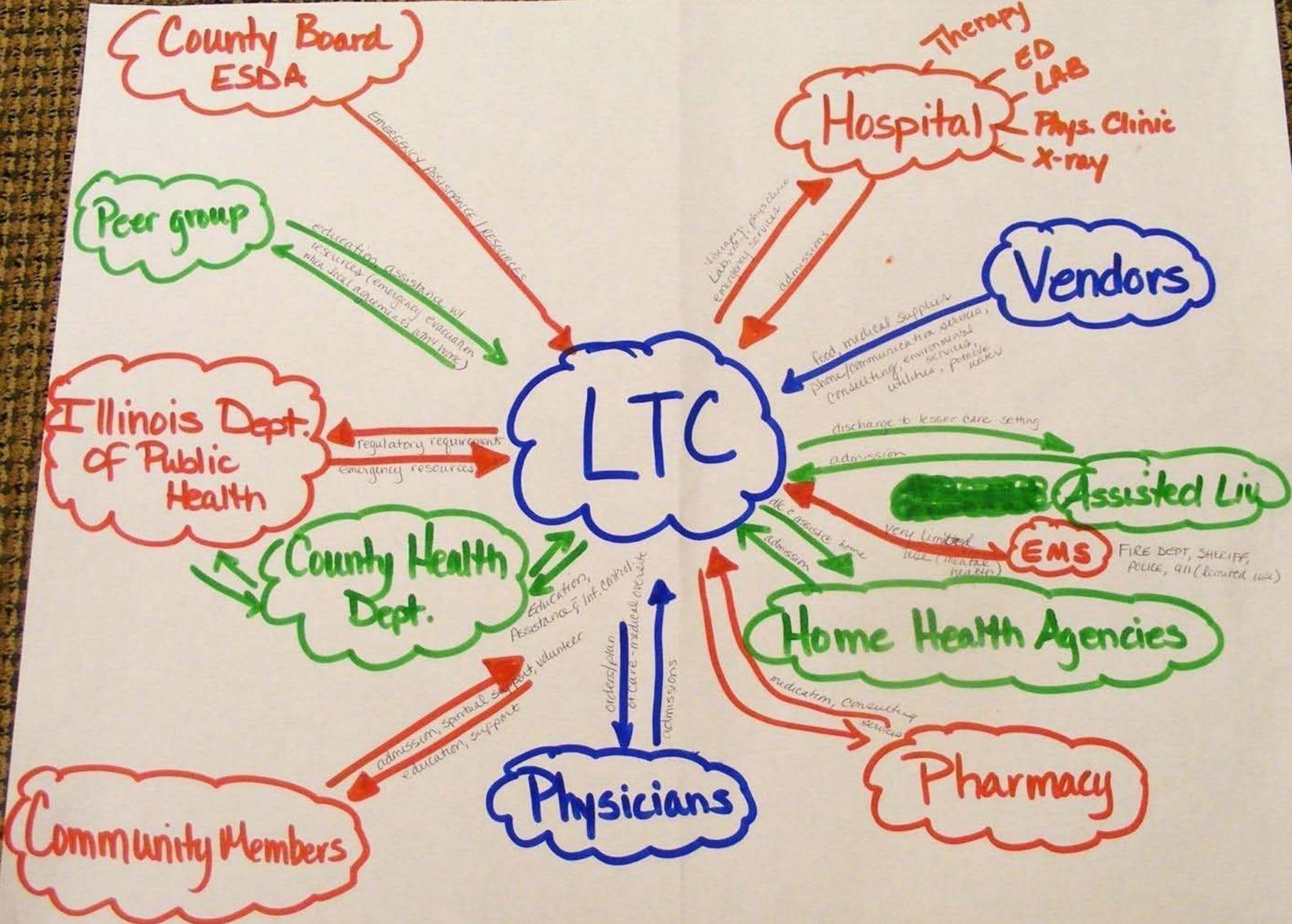
Issues and Strategies



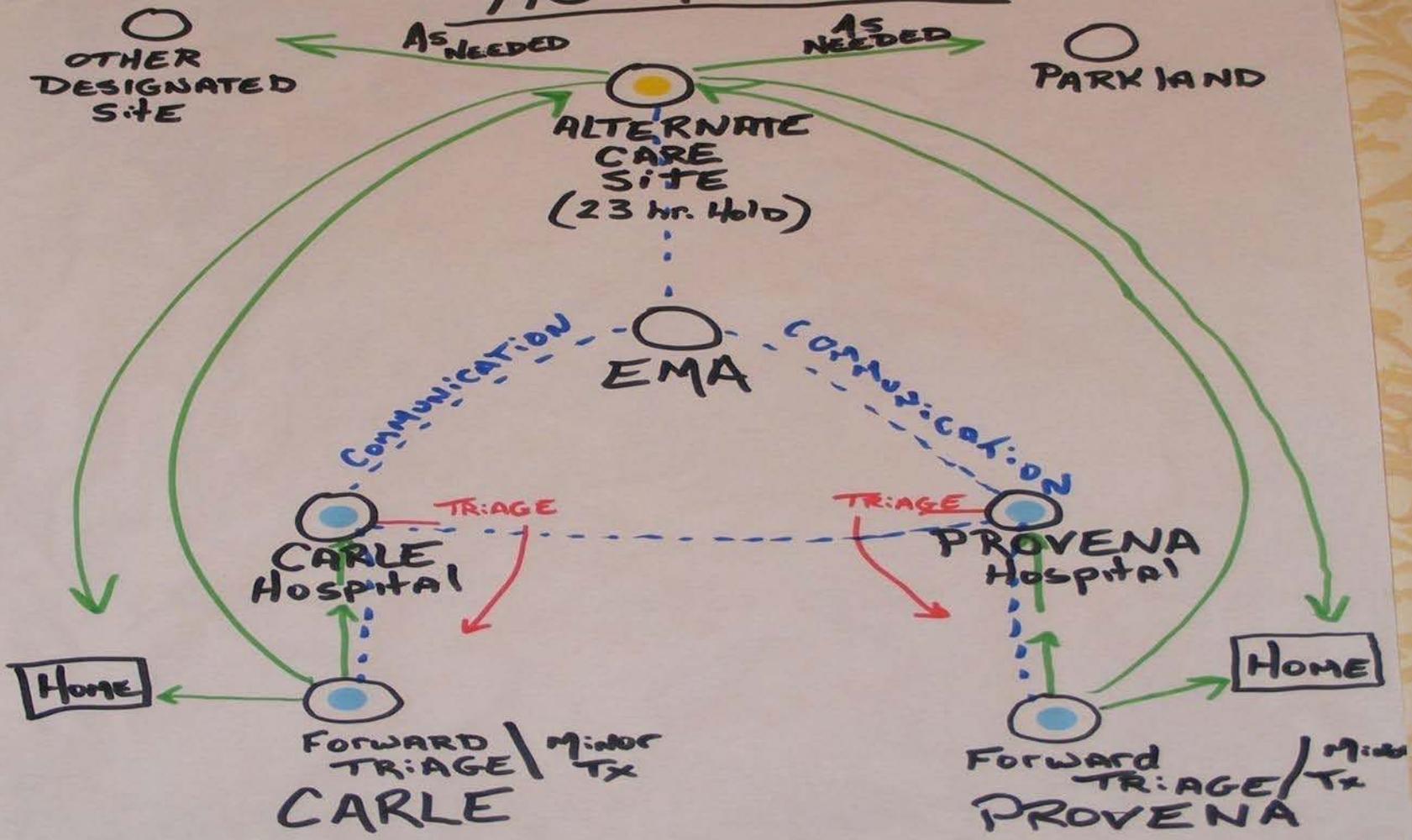
Diagram of Healthcare Delivery Model

- From where do they receive patients?
- To where do they send patients?
- Where are the chokepoints in patient flow?
- What are the alternatives?
- At what points can they assist other critical sectors?





HOSPITAL



Resource Identification

- Identify and capture a list of resources from each sector
 - Needed to respond during a pandemic
 - Currently stockpiling
 - Available to share with other sectors during an emergency
- Identify chokepoints associated with resource sharing and overlapping MOUs and MOAs





School Bus



Fair Grounds



Laboratory



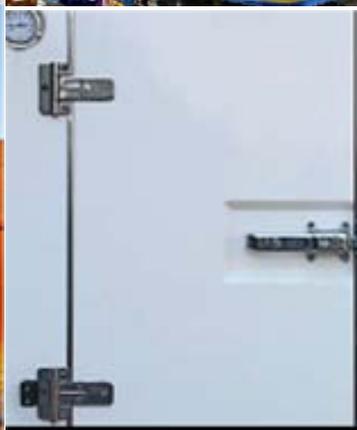
Doctor



Beds



Converted Building



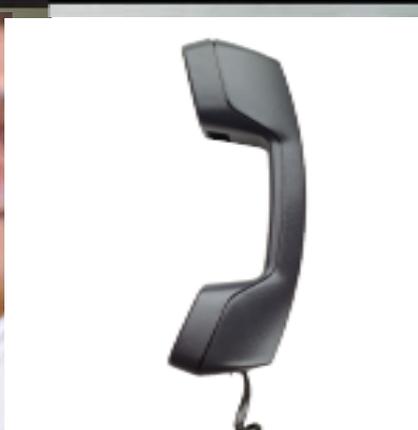
Refrigerator



N-95 Respirator



Volunteers



Telephone



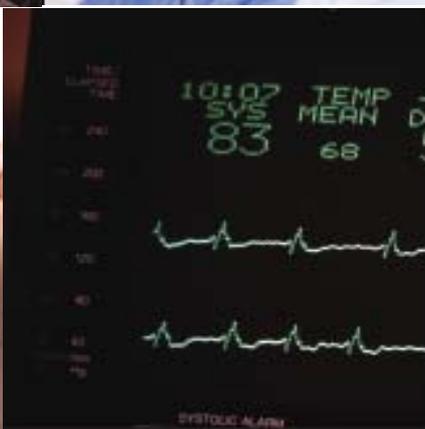
Gloves



Operator



Pager



Mechanical Ventilators



Antivirals

Discussion Break



CENTERS FOR DISEASE CONTROL & PREVENTION



Lessons Learned

- Sectors did not know of each other's plans
- Sectors made incorrect assumptions about each others plans
- Hospital leadership had not grasped the complexity of the issues and the need to integrate their planning with the community
- Role of PH in healthcare delivery was not clear to themselves and to the other sectors
- Most effective communities included public health, healthcare, and emergency management in their planning efforts – lead did not matter



Conclusions

- Entire process takes up to 12-18 months with communities reworking their model as they develop their implementation plans
- Participants reported significant improvements in knowledge about their community's capability and capacity, and their level of preparedness
- Framework for effective community planning and preparedness requires a core team that includes public health, healthcare, and emergency management



Healthcare Preparedness Team

- CDC/DHQP
 - Adeyelu Asekun
 - Kelly Dickinson
 - Kathy John
 - Brian Kolodziejski
 - Sherline Lee
 - Jean Randolph
 - Alcia Williams
- ORISE
 - Will Artley
 - Ron Edmond
 - Freddy Gray
 - Linda Hodges
 - Michael Outler
 - Jennifer Reynolds
 - Betsy Smither
 - Amber Tayman
 - Casey Thomas
 - Kelly Williams

