A Workbook for Community Planners Preparing for Medical Surge

Summit County Health District
Summit County Emergency Management Agency
Akron Regional Hospital Association

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DEVELOPMENT OF AN ALTERNATIVE CARE SYSTEM

A Workbook for Community Planners Preparing for Medical Surge

EXECUTIVE SUMMARY

In an effort to systematically address the challenges of a medical surge situation, Summit County, Ohio made the decision to develop a comprehensive alternative care system, rather than identifying individual alternative care sites. Through this process, a range of options were researched and developed, with the intent of meeting the needs of the community during a medical surge situation by providing varying levels of education and care. The options range from public education and the use of a public call-center, all the way to standing up a full-scale hospital for influenza patients.

This systematic process included comprehensive, county-wide resource assessment, development of discipline-specific profiles and assumptions, and a general education component as to the capabilities of affected disciplines. The process also provided an opportunity for community partners to exchange information and learn about the roles and responsibilities of each discipline on a day-to-day basis.

A county stakeholders' meeting proved instrumental in identifying advantages and disadvantages of each potential option, and also helped determine which option(s) would be implemented at the time of a medical surge event. The input of key decision makers helped facilitate the county-wide integration of this model into the Summit County Emergency Operations Plan, with each option further developed regarding its implementation within the community.

OVERVIEW

Introduction

According to the U.S. Department of Health and Human Services, medical and health systems in the United States face the increasing probability of major emergencies or disasters involving human casualties. Such events will severely challenge our ability to adequately care for large numbers of patients (surge capacity) and those patients with unusual or highly specialized medical needs (surge capability).

The first step to address medical surge is using management systems for medical and health response to major emergencies and disasters, along with developing and maintaining preparedness programs.

Effective strategies for addressing the challenges of medical surge capacity/capabilities require a systematic approach to meet patient needs that challenge or exceed normal operational abilities, while preserving quality of care and the integrity of the healthcare system.

Addressing the challenges of a medical surge situation has proven to be a monumental task for local communities throughout the United States. Challenges include, but are not limited to, resources (human/material), facility identification/management, legal liability, transportation issues, triage, determining levels of care and deciding who will provide medical oversight in these situations.

Purpose

The purpose of this workbook is to assist counties in the development of an alternative care system through a structured process that can be modified to meet the needs of their communities.

Target Audience

This workbook is county-focused, directed toward entities such as emergency management agencies, public health, hospitals, government officials, legal representatives, first responders, social service agencies, faith-based organizations, schools, court systems and health care services.

Format

Each section of this workbook will identify general steps and specific tasks that individual counties may choose to undertake in the development of their alternative care system. An estimated timeframe for each step is included, and users will find that within each task, Summit County has shared the process that they followed, as well as the experience and lessons learned that they encountered in the development of their county-wide alternative care system. Documents that Summit County developed and used are included in the Attachments Section at the end of the workbook.

STEP 1: DEVELOPING A FRAMEWORK

Time Frame: Based on weekly meetings, approximately 4 weeks

Task 1.1 – Establish the Planning Team

Building a solid initial planning team is a crucial part of the process. It is a good idea to:

- Involve people who will already have buy-in to your proposition, as well as those with whom you have a good working relationship
- Begin with the easiest partnerships to leverage, and those with the biggest stake in the results
- Involve those with "political savvy" who can bridge any political barriers that may be encountered
- Involve those community members who will bring experience and expertise to the table
- Designate one person to take the leadership role in order to keep the planning team on task.

WHAT SUMMIT COUNTY DID…

The Summit County planning team included representatives from the Emergency Management Agency (EMA), hospitals, and public health, as well as a scribe to capture information as it was processed over the scope of the entire project.

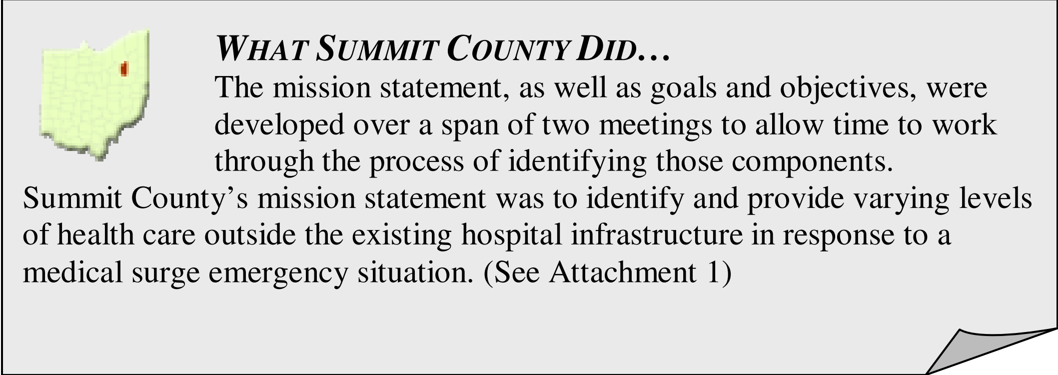
Summit County has a long history of collaboration on initiatives which allowed for the development of a strong and cohesive planning team. A key component to the success of the planning team was keeping the team small. The smaller team was able to accomplish more, there was greater availability for meetings, the members had a solid knowledge base of community resources, and if specific information was required for a certain task, the members knew where to go for information.

The public health representative acted as the lead of the planning team.

LESSONS LEARNED: Keeping the planning team small was a very effective strategy.

Task 1.2 – Establish the Mission of the Alternative Care System

The planning team will need to develop a mission to define the purpose of the project. This will be important in communication with stakeholders as it relates to the development of the Alternative Care System concepts.



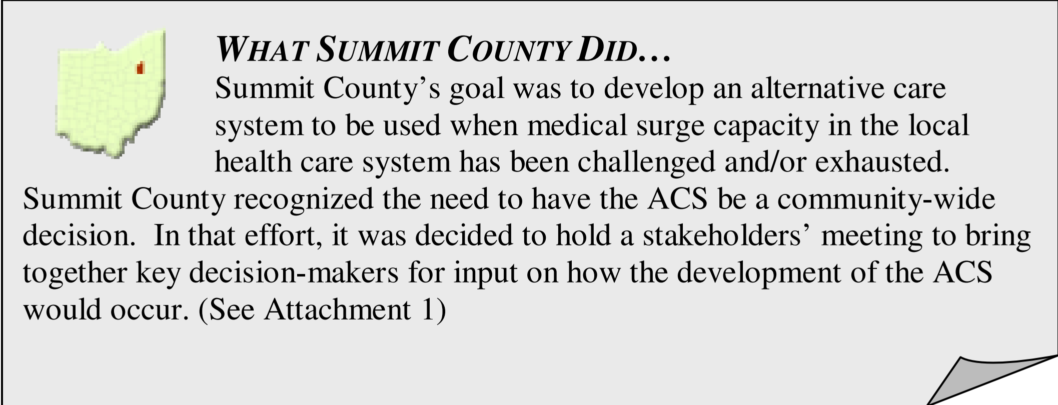
WHAT SUMMIT COUNTY DID…

The mission statement, as well as goals and objectives, were developed over a span of two meetings to allow time to work through the process of identifying those components.

Summit County's mission statement was to identify and provide varying levels of health care outside the existing hospital infrastructure in response to a medical surge emergency situation. (See Attachment 1)

Task 1.3 – Develop Goals and Objectives of the Alternative Care System

Goals and objectives will need to be developed specifically for your community, based on what is envisioned for your community's alternative care system.



WHAT SUMMIT COUNTY DID…

Summit County's goal was to develop an alternative care system to be used when medical surge capacity in the local health care system has been challenged and/or exhausted.

Summit County recognized the need to have the ACS be a community-wide decision. In that effort, it was decided to hold a stakeholders' meeting to bring together key decision-makers for input on how the development of the ACS would occur. (See Attachment 1)

Task 1.4 – Establish Frequency of Planning Team Meetings

The process of developing the alternative care system is a lengthy one and it is important that the planning team is committed to the full process. The timetable and frequency of meetings should be based on the desired end product (workshop, development of plan, etc.)

WHAT SUMMIT COUNTY DID…

Summit County's planning team met every other week, based on availability and the necessary timeframe for planning a large stakeholders' meeting.

Task 1.5 – Determine the Date and Location for the Stakeholders' Meeting

Considerations for holding a stakeholders' meeting include: location for the meeting; length of the meeting; finances (who will support the costs of the stakeholder meeting), and availability of the stakeholders and the planning team.

WHAT SUMMIT COUNTY DID…

Summit County held their stakeholders' meeting in September 2008 in Chautauqua, NY over a 2-1/2 day period, with approximately 55 people in attendance. The month of September was chosen based on the availability of the majority of invited participants, as well as weather conditions. The location was chosen because Chautauqua is approximately 150 miles from Summit County, and experience has shown that the best results are yielded when participants are at a sufficient distance that they cannot return home or back to work on a daily basis. The location also provided important opportunities for networking outside the work environment. Summit County's finances were grant-supported.

Task 1.6 – Establish Time Frame for the Project

Assuming the end goal of a stakeholders' meeting, establishment of the time frame should include consideration of the time necessary to complete following:

Confirming date, time, and location
Working out transportation, food and reimbursement issues
Developing discipline-specific profiles/assumptions
Developing list of invitees (with rationale for who is invited)
Inviting participants (preliminary calls, written invitations, RSVPs)
Identifying tools to be used at the stakeholders' meeting
Creating agenda for stakeholders' meeting
Assigning breakout sessions (participants and facilitators)
Preparing documents and materials needed for stakeholders' meeting
Establishing method for deciding on alternative care system options
Holding the stakeholders meeting

WHAT SUMMIT COUNTY DID…

Summit County began working on this project in November 2007. The planning team established a time frame of November 2007 to September 2008 to accomplish all of the tasks identified above.

STEP 2: DEVELOPING DISCIPLINE PROFILES

Time Frame: Approximately 4 months

In order to understand how community resources will be incorporated into an emergency response, it is important to gain a sense of what specific resources are currently available in your community. In an effort to broaden understanding of local resources, discipline-specific profiles for all stakeholders were developed so that Summit County could determine what resources existed in the community, which in turn helped to determine which ACS options would be viable. Additionally, the compilation of the discipline profiles provided a tangible resource document to be used at the stakeholders' meeting.

Task 2.1 – Establish Objective(s) for Profile Development Process

Identify why you want to assess your resources. The process of identifying community resources may provide opportunities to gain additional information relevant to the parties involved.

WHAT SUMMIT COUNTY DID…

Summit County developed three objectives related to the profile development process:

- Identify disaster assumptions pertinent to each discipline, based on a pandemic influenza situation
- Identify resources that will be available during a pandemic influenza situation
- Identify at what point resources will be exhausted during a pandemic influenza situation.

Task 2.2 – Identify Disciplines to Profile

Consider disciplines that will be directly impacted by a medical surge situation and who may be relied upon to assist in the response.

WHAT SUMMIT COUNTY DID…

Summit County developed profiles for the disciplines listed below. Information was gathered in face-to-face meetings, one per discipline, using an informal, open-ended approach.

- Public Health
- Hospitals*
- Dispatch/Communication Centers
- Fire/EMS
- Law Enforcement
- Home Health Care
- Primary Care Physicians' Offices
- Urgent Care Centers
- American Red Cross Blood Services
- Social Service Agencies (including: Children's Services Board; Area Agency on Aging; Summit County Board of Mental Retardation/Developmental Disability; Alcohol, Drug and Mental Health Board; Department of Jobs and Family Services; Haven of Rest [homeless shelter]; International Institute)

*Note: Summit County identified two categories of health care services: hospital care and out-of-hospital care.

LESSONS LEARNED:

- It was difficult to get long-term care facilities to the table due to the disparate and complex nature of that industry.
- It was difficult for primary care physicians to commit resources and time, but potential for reaching this group exists through the Office Managers' Association.
- Social service agencies proved to be such a diverse group with such widely varying characteristics that it was decided to meet again separately with the larger social service agencies, to ensure that their information was appropriately captured.
- Summit County identified the following additional disciplines to be profiled: the court system; sheriff's office; incarceration facilities; probation department; faith-based organizations; dialysis centers and schools.

Task 2.3 – Determine Invitees from Disciplines

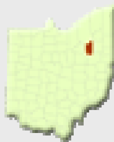
Invitations to the discipline profile meetings should be directed to upper management personnel, so that they will not only be able to provide accurate information relating to resources and services provided by their discipline, but also have the authority to implement policy changes. Representation should be considered for small, medium and large jurisdictions within the county, as well as each discipline specifically represented (for example, multiple health departments and hospitals within the county).

WHAT SUMMIT COUNTY DID…

Based on the disciplines identified in Task 2.2, executive-level representatives were invited to the discipline profile development meetings. Representatives from Fire/EMS, law enforcement and Dispatch were invited from small, medium and large jurisdictions in the county. Each of the three health departments in the county sent representatives from their Environmental Health, Nursing, Epidemiology and Administration divisions. Hospitals were represented by the Akron Regional Hospital Association, which developed the regional hospital pandemic influenza guidelines. The larger social service agencies were represented and it was subsequently determined to meet again with that group because of the widely divergent focus of the numerous social service agencies in the county.

Task 2.4 – Address Logistics of Discipline Profile Meetings

Determine location, date and time and send out invitations.



WHAT SUMMIT COUNTY DID…

Summit County's discipline profile development meetings were all held at the Summit County Emergency Operations Center, which provided an opportunity for agencies unfamiliar with the EOC to gain understanding about its role and function and view it first hand. The duration of each discipline's meeting was approximately two hours, and two meetings were held per day. Invitations to the profile development meetings were sent out via email.

Task 2.5 – Develop Questions to Ask of Each Discipline Being Profiled

Questions should be developed to identify human and material resources, status of pandemic influenza and Continuity of Operations plans (COOP), surge capacity, communication pathways, existing mutual aid agreements, just-in-time training capacity, social distancing options, and workforce limitations in response to an emergency. Questions should be very discipline-specific and open-ended.

WHAT SUMMIT COUNTY DID…

General information was obtained about individual agencies, including the services they provide, hours of operation and general availability of resources (human and material). Additionally, the following information was gathered:

- How they communicate with their clients and staff
- At what point internal resources would be exhausted and the steps they would take then
- How an absenteeism rate of 40% for 10-14 days would impact the daily function of their agency
- Whether they have COOP and/or pandemic plans in place
- Feasibility of just-in-time training
- Impact of social distancing recommendations

Task 2.6 – Identify Experienced Facilitators to Conduct Discipline Profile Meetings

It is important to have experienced facilitators to guide discussion, ask pertinent, open-ended questions, keep conversation focused and extract relevant information from participants.

WHAT SUMMIT COUNTY DID…

Summit County used members of the planning team as facilitators, which helped provide continuity throughout the discipline assessment process and subsequent profile development.

Task 2.7 – Create Discipline Profiles

The discipline profiles are intended to provide a "snapshot" of each discipline. Based on the information obtained during the discipline profile meetings, consider including assumptions about each discipline, pertinent to pandemic influenza as well as an all-hazards situation, human and material resources available and status of emergency plans. In addition, you may wish to develop general assumptions pertinent to all disciplines as they relate to community containment, volunteers and resource availability.

WHAT SUMMIT COUNTY DID…

The planning team gathered general resource information about each discipline prior to meeting with them, so that the information could be confirmed by those in attendance, rather than "starting from scratch."

Summit County developed assumptions for the following disciplines:

- Public Health
- Hospitals
- Law Enforcement
- Fire/EMS
- Social Service Agencies
- Schools

Additionally, General Assumptions were developed, as well as assumptions for the state health department. (See Attachment 2.)

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STEP 3: DEVELOPING THE OPTIONS DOCUMENT

Time Frame: 3-6 months

Task 3.1 – Research Existing Alternate Care Site Plans and Develop Rationale for Developing Options Document

As your community plans for meeting the challenges of a surge on your health care systems, identify the options that your community could use as they develop an alternative care system.

WHAT SUMMIT COUNTY DID…

Summit County researched and located the following article, "The Prospect of Using Alternative Medical Care Facilities in an Influenza Pandemic." Additional information was gathered from the sources listed at the end of the document entitled "Proposed Summit County Alternative Care System Options (A Summary)."

Task 3.2 – Establish Potential Levels of Care outside the Hospital Setting

Based on research from Task 3.1, identify potential possibilities for expansion of existing health care, as well as identifying potential health care services that may be provided. Identify community partners to provide feedback on the document, based on adequate representation of the disciplines involved.

WHAT SUMMIT COUNTY DID…

Summit County created an Options Document detailing potential levels of care outside the hospital setting. (See Attachment 3 .) Feedback in the development of this document was provided by the Centers for Disease Control and Prevention and the Oak Ridge Institute of Science and Education.

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STEP 4: PREPARING FOR THE STAKEHOLDERS' MEETING

Time Frame: This should be done **concurrently** with the first 1-3 steps

Task 4.1 – Establish Mission, Purpose, Goals and Objectives

Within the planning team, identify mission, purpose, goals and objectives for the stakeholders' meeting, in order to communicate with community partners the reason for their commitment and participation.

WHAT SUMMIT COUNTY DID…

Summit County's **mission** was to identify and provide varying levels of health care outside the existing hospital infrastructure in response to a medical surge emergency situation. The **purpose** of the workshop was to bring together pertinent decision-makers from public health, hospitals, health care, fire, law enforcement, emergency medical services, emergency management agency, special needs organizations, dispatch centers, businesses, community, elected officials, schools, faith-based organizations, Medical Reserve Corps, Medical Society, and state partners to identify and address issues associated with alternative care during an influenza pandemic in Summit County, Ohio. The **goal** was to develop an alternative care system to be used when medical surge capacity in the local healthcare system has been challenged and/or exhausted. The **objectives** were divided into pre-workshop, workshop, and post-workshop segments.

Pre-workshop objectives:

- Create a written, step-by-step explanation for the process that Summit County used to reach decisions regarding an ACS (this was done as a grant requirement).
- Conduct seven workshops during May, June and July 2008 with identified community groups, each with the same objectives – to have participants identify five disaster assumptions, five resources available to their group/organization, and trigger points at which their resources would be exhausted.
- Compile a document for the workshop detailing the profiles of the identified groups (the "Discipline Profiles").
- Compile a document for the workshop detailing the range of options for the Alternative Care System (the "Options Document").
- Compile a document for the workshop detailing the process to be used for facilitation.

continued…

Workshop objectives:
By the end of the Workshop, the following should occur:

Begin to identify:

- Specific parameters/triggers
- Involved partners
- Roles and responsibilities of individual involved partners
- Parameters/triggers for the use of individual levels of the established Alternative Care System

Develop outputs:

- A decision tree of when to "turn on" the ACS (triggers)
- How the ACS gets put into place (should be a fluid concept of ramping the ACS up and back down again)
- How a decision is made regarding who does what in keeping the ACS sustainable (tiers of care)
- The advantages and disadvantages of each ACS option
- The ACS options that will work best in Summit County

Post-workshop objectives:

- Develop an education tool
- Develop an exercise utilizing the education tool

Task 4.2 – Confirm Date, Time, Location, Transportation, Food and Reimbursement Issues

Things to consider: time of year (weather, election season), large community events, length of conference (balancing how many hours/days it is feasible for stakeholders to be away from the community with a realistic timeframe to accomplish goals and objectives), funding availability as it relates to transportation, food and lodging, and participants' preference to staying overnight or going home.

WHAT SUMMIT COUNTY DID…

Summit County chose late September to have our 2-1/2 day workshop in Chautauqua NY, which was approximately 2 hours from Summit County. The workshop was held at a hotel and paid for through a CDC grant. Historically, Summit County has found that active participation and commitment from stakeholders have been enhanced when the location has been far enough from home base to discourage participants from returning home after each day. The location that Summit County chose also provided opportunities for recreation and networking.

Task 4.3 – Develop List of Invitees

It is important to get high-level decision-makers from identified agencies within your community that would be involved in planning and response. Consider hospitals, elected officials, public health, schools, social service agencies, faith-based organizations, long term care facilities, court systems, law enforcement, fire/EMS, American Red Cross, emergency management agencies, incarceration facilities, legal representation, state and federal partners (health, hospital, EMA), cross-border partners, primary care physicians, home health care, hospice organizations, medical societies.

WHAT SUMMIT COUNTY DID…

The planning committee identified specific individuals from identified disciplines to be invited to the workshop. The individuals were selected based on their authority to speak for their agency/organization, and history of active participation in these types of discussions. In order to meet the objectives of the workshop, the planning team did not allow an invited individual to send a representative on their behalf. If an invited individual could not come, the planning team selected another representative.

LESSONS LEARNED: Despite advance planning, some high-level decision-makers were not available, and Summit County identified additional disciplines that should have been invited, such as legal, home health care, hospice, court system, American Red Cross.

Task 4.4 – Invite Participants

Develop a process for inviting participants, and identify the necessary timeframe for invitations and RSVPs. Consider personal phone calls, written invitations, save-the-date cards, RSVPs, email reminders and follow up phone calls.

WHAT SUMMIT COUNTY DID…

Multiple methods were utilized to invite participants, starting with direct, personalized phone calls in which the goals, objectives and time commitment of the workshop were detailed. A standardized invitation was mailed to participants 3-4 months prior to the event, along with information on the venue, reimbursement issues and a registration form. Follow up phone calls were made in order to confirm commitment. The goals, objectives and time commitment were detailed in all modes of communication.

Task 4.5 – Identify Tools to Use at the Stakeholders Meeting

Determine which tools/equipment will be used at the stakeholders' meeting. Consider the following:

Laptop	Projector	Flip charts
Podium	Portable microphone(s)	Markers
Name tags/table tents	Candy (rewards)	Notepads/pens
Participant notebook	Facilitation tools	

WHAT SUMMIT COUNTY DID…

Summit County worked with ORISE to develop the facilitation tools that were used at the workshop (See Attachment 4). Summit County assembled the participant notebooks and ORISE provided the other tools utilized during the workshop.

Task 4.6 – Create Agenda for Stakeholder's Meeting

Based on the length of your meeting, identify speakers, topics of discussion (include introduction, purpose, objectives, background work done prior to stakeholders meeting, and specific scheduled activities to be implemented).

WHAT SUMMIT COUNTY DID…

The planning team worked with ORISE to develop the agenda. Based on a two-and-a-half day workshop, the agenda included an introduction of the project, introduction of the participants, review of the purpose and objectives, sharing of the discipline-profiling process, educational information regarding pandemic influenza and the scope and function of the Emergency Management Agency, an introduction of the Options Document, facilitation of small group breakout sessions and the final decision of the group. (See Attachment 5)

Task 4.7 - Assign Breakout Sessions (participants and facilitators)

Assign breakout sessions based on participants' discipline, to ensure that there is adequate representation of each discipline within the workgroups. It will be necessary to have strong facilitators for the breakout sessions to keep discussion on track and ensure all voices are heard.

WHAT SUMMIT COUNTY DID…

Participants were assigned to one of four breakout groups to ensure there was adequate representation of each discipline in each workgroup. Summit County attempted to have representatives from the following disciplines in each workgroup: law enforcement; dispatch; EMS/fire; hospitals; physicians; faith-based organizations; schools; public health. Based on the limitations of the number of attendees, some disciplines were not represented in each group. Summit County utilized ORISE staff to facilitate the breakout sessions.

LESSONS LEARNED: Stronger representation from hospital senior management, representatives from Akron Public Schools, more representation from long-term care facilities, elected officials and other identified community partners would have been beneficial.

Task 4.8 – Prepare Documents Needed for Stakeholders Meeting

Consider developing a notebook for participants containing the following items:

- Community profiles with census information
- Discipline-specific profiles
- Options document
- Copies of PowerPoint presentations
- Evaluation tools
- Agenda
- Comment cards
- Community maps
- Goals and objectives
- Reference documents (glossary of terms and acronyms)
- Participant list
- Reimbursement paperwork

WHAT SUMMIT COUNTY DID…

Summit County prepared participant notebooks with the documents listed above. (See Attachment 6)

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STEP 5: THE STAKEHOLDERS' MEETING

Time Frame: The time frame will depend on the goals and objectives, availability of participants and financial resources.

Task 5.1: Holding the Stakeholders Meeting

The meeting room will need to be conducive to facilitating conversation and information-sharing; for example, utilizing round tables in large group meetings and U-shaped tables in breakout sessions. Having the group dine together (breakfast/lunch) provides additional opportunities for networking and team building. Cross-discipline interaction should be encouraged.

WHAT SUMMIT COUNTY DID…

Summit County hosted a pre-workshop dinner at the hotel the night before the workshop began to allow time for networking and information sharing. During the workshop, breakfast and lunch were provided for the participants in the meeting room. The planning team did not participate in the breakout sessions to avoid dominating the groups and skewing the outcome of the decision-making process. Additionally, since the breakout sessions were facilitated by ORISE staff, the planning team was able to serve as a resource for information specific to Summit County.

Task 5.2 – Establish Method for Deciding on Alternative Care System Options

Based on community resources, attendees, outcomes of breakout sessions and facilitation techniques, the larger group will make the decision on what their community's alternative care system will entail.

WHAT SUMMIT COUNTY DID…

Following the breakout sessions, each workgroup shared the advantages and disadvantages that had been identified for each option. Working within the larger group, it was decided which identified options would be further developed. Identification of future planning efforts to be implemented was shared.

LESSONS LEARNED: Consider convening discipline-specific small groups to allow for feedback within each discipline prior to the large group facilitation process. Identify specific large-group facilitation tools to ensure each stakeholder has a voice in the decision-making process.

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STEP 6: AFTER THE STAKEHOLDERS' MEETING

Time frame: As of August 2009, this is an ongoing process

Task 6.1: Reassess Planning Team Mission and Members

Based on recommendations from the stakeholders' meeting, reassess current mission and revise as necessary. Identify any additional members that need to be brought into the planning team.

WHAT SUMMIT COUNTY DID…

Following the stakeholders' meeting, the planning team determined that the mission did not change, and identified the need to include hospital emergency preparedness personnel on the planning team.

Task 6.2: Create Specific Subcommittees to Address Disadvantages

Based on the identified disadvantages of the ACS options, create specific community subcommittees to address disadvantages for each option.

WHAT SUMMIT COUNTY DID…

Prior to 2001, Summit County developed the Domestic Preparedness Task Force (DPTF), which is a subgroup of the Summit County Emergency Management Executive Committee. There are currently a number of subcommittees under the DPTF that work on target capabilities related to homeland security planning and response capabilities. Existing DPTF subcommittees include Law Enforcement, Public Health, Public Information, Mortuary Care and Mental Health. The ACS planning team created the following subcommittees that were not currently operating under DPTF:

- Legal
- Transportation
- Hospital
- Public Health and Hospital
- Triage
- Social Service

Mission statements were developed and individuals were assigned to subcommittees. The majority of individuals assigned had attended the stakeholders meeting, and several were brought in from the community. (See Attachment 7)

Task 6.3: Assign Disadvantages for Each Option to Subcommittees

Connect specific disadvantages to subcommittees based on their mission.

WHAT SUMMIT COUNTY DID…

As an example, the Legal Subcommittee established in Summit County meets on a quarterly basis to address legal issues which pertain to each of the options. Participants include not only local representatives, but state-level legal personnel as well.

Task 6.4: Identify Any Additional Profiles to be Created

Based on outcomes from the stakeholders' meeting, identify any additional disciplines that need to be profiled in your community.

WHAT SUMMIT COUNTY DID…

Following the stakeholders' meeting, Summit County profiled the following:

- Faith-Based Organizations
- Court System
  - Municipal Court
  - Court of Common Pleas
  - Clerk of Courts
  - Prosecutor's and Public Defender's Offices
  - Domestic Relations Court
  - Probate Court
  - Oriana House (community-based corrections facilities)
  - Summit County Sheriff's Office/Summit County Jail
  - Juvenile Court
- Social Service Agencies
  - Haven of Rest (homeless shelter)
  - Alcohol, Drug and Mental Health Board
  - Summit County Board of MRDD
  - Summit County Children's Services Board
  - Summit County Dept. of Job and Family Services
  - International Institute
  - Area Agency on Aging
- Health Care
  - Home health care agencies
  - Dialysis centers
  - Physicians' offices

LESSONS LEARNED: Additional disciplines that will need to be profiled include long-term acute care hospitals, large outpatient care centers, long-term care facilities, and hospice.

Task 6.5: Facilitate Subcommittee Meetings to Address Disadvantages

Set meeting dates and times based on participants' availability. Work through disadvantages to identify potential solutions.

WHAT SUMMIT COUNTY DID…

This is currently an ongoing process in Summit County. The Hospital Subcommittee met weekly, the Public Health and Hospitals Subcommittee met bi-weekly, the Legal Subcommittee meets quarterly, and the Triage Subcommittee meets every 6 weeks. Other committees meet according to time lines set forth by the Domestic Preparedness Task Force.

Task 6.6: Develop Alternative Care System Plan Document

Based on your community's emergency operations plan, develop the appropriate annex/emergency support function/appendix/tab for use at the time of an emergency event.

WHAT SUMMIT COUNTY DID…

This is currently on ongoing process. Summit County will be creating for the Summit County Emergency Operations Plan an Alternative Care System Appendix to Annex H: Medical Care, with tabs to identify the process to follow for the seven individual options.

Task 6.7: Reconvene Stakeholders for Alternative Care System Report-Out

Identify timeline to reconvene stakeholders to provide report of alternative care system project development. Identify tools that have been developed and share with the stakeholders. Identify next steps.

WHAT SUMMIT COUNTY DID…

This is currently in process for Summit County..

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STEP 7: EDUCATION / TRAINING / EXERCISE

Time Frame: To be developed

Task 7.1: Develop and Implement Education and Awareness Program

Identify community partners who need **awareness-level education** and determine who will conduct the session(s). This education will provide an overview of the alternative care system, how decisions will be made and how resources will be allocated.

WHAT SUMMIT COUNTY DID…
To be developed

Task 7.2: Develop and Implement Training Program

Identify which disciplines will need to attend **operations-level trainings**. Identify the length, location, materials, agendas, evaluation tools. This training is to provide more detailed information regarding the operations of the various options that have been identified by your community. Determine who will provide the training (consider train-the-trainer curriculum).

WHAT SUMMIT COUNTY DID…
To be developed

Task 7.3: Develop and Implement Exercise Program

Develop timeline of exercise program(s). Consider a county-wide exercise design team and utilization of the HSEEP building block approach.

WHAT SUMMIT COUNTY DID…
To be developed

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ATTACHMENTS

ATTACHMENT 1: SUMMIT COUNTY ALTERNATIVE CARE SYSTEM MISSION STATEMENT, GOAL AND OBJECTIVES

The mission statement of the Summit County Alternative Care System is to identify and provide varying levels of health care outside the existing hospital infrastructure in response to a medical surge emergency situation.

The goal of the Summit County Alternative Care System is to develop an alternative care system to be used when medical surge capacity in the local healthcare system has been challenged and/or exhausted.

The objectives of the Summit County Alternative Care System are to:

1. Develop the Summit County Call Center to be utilized at the time when hospitals have the potential to surge quickly during an emergency.

2. Develop triage tools to be used at the time of a pandemic influenza situation.

3. Develop educational tools to disseminate to Summit County residents prior to a pandemic influenza situation to provide at home care instructions.

4. Identify locations in Summit County to set up sites for alternate care outside of the hospital system.

5. Identify which Summit County agencies will have oversight of the alternate care site locations.

6. Identify resources (medical/human) needed at all alternate care site locations.

7. Develop Memorandums of Understanding documents for all locations to be used as part of the Alternative Care Sites.

8. Identify legal/ethical issues to consider with the implementation of the Alternative Care Systems.

9. Develop transportation plans to be utilized at the time that the Alternative Care System is implemented.

SUMMIT COUNTY DISCIPLINE PROFILES

Discipline: **LAW ENFORCEMENT**

DESCRIPTION

- ___ law enforcement agencies
- ___ sworn officers
- Each city, village or township has a charter which enables their law enforcement officers to operate under general provisions
- Additionally, all officers are bound by Ohio Revised Code.

AVAILABLE RESOURCES

- ___ Response vehicles
- ___ DARE vehicles
- ___ Marine patrol vehicles
- ___ SWAT teams
- ___ Unmarked clandestine units
- ___ Push trucks
- ___ Motorcycles
- ___ Trained K-9s

HUMAN RESOURCES FT=Full-time • PT=Part-time • AUX=Auxiliary • ADM=Administrative • RSV=Reserve

Akron
___ Officers • ___ Supervisors • ___AUX

Barberton
___ Officers • ___ ADM

Bath
___ FT • ___ ADM

Boston Heights
___ FT • ___ ADM • ___ AUX

Copley
___ FT • ___ ADM

Fairlawn
___ Officers • ___ ADM

Hudson
___ FT • ___ ADM • ___ AUX

Lakemore
___ FT • ___ PT • ___ RSV • ___ ADM

Munroe Falls
___ Officers • ___ ADM • ___ AUX

New Franklin
___ FT • ___ • PT ___ 1 ADM

Northfield Village
___ FT • ___ PT • ___ ADM

Norton
___ FT • ___ ADM

Richfield
___ Officers • ___ ADM

Silver Lake
___ Officers • ___ ADM • ___ AUX
___ Animal Control

Springfield
___ FT • ___ PT • ___ ADM

Stow
___ Officers • ___ ADM • ___ AUX

Summit County Sheriff
___ Officers • ___ ADM • ___ AUX

Tallmadge
___ Officers • ___ ADM • ___ AUX

Twinsburg
___ FT • ___ ADM

The University of Akron
___ FT • ___ ADM

EXAMPLE

ASSUMPTIONS

- Just-in-time training will not be utilized within law enforcement agencies.
- Law enforcement will not be used for security or crowd control situations.
- Service departments may be used for traffic and crowd control situations, under the direction of law enforcement agencies.
- Social distancing options are very limited within the law enforcement community.
- Law enforcement agencies use familiar mutual aid for assistance, and are supported by the Summit County Sheriff's Office.
- The use of personal protective equipment (PPE) will be extremely limited.

EXAMPLE

SUMMIT COUNTY DISCIPLINE PROFILES

Discipline: **HOSPITALS**

DESCRIPTION – There are 6 acute care hospitals in Summit County which offer the following services: oncology, pulmonary, orthopedics, cardiac, neurology, labor and delivery, general medical and surgical services. Akron Children's Hospital specializes in pediatric care and also has an adult and pediatric burn unit.

*** Items marked with an asterisk (*) are defined on the following page.**

AVAILABLE RESOURCES:

EXAMPLE

AKRON CHILDREN'S HOSPITAL	AKRON CITY HOSPITAL
*Trauma Level II Pediatric Center Pediatric Emergency Room: ___ Beds *Licensed Beds: ___ *Surge Beds: ___ ___-Bed Burn Unit Pharmacy 24/7 Off-Site Facilities: AKRON CHILDREN'S AT HUDSON 4pm-11pm Monday – Friday 11am-11pm Saturday, Sunday ___ Beds No Pharmacy No Overnight Stays Limited capability in housing patients in a mass casualty AKRON CHILDREN'S MONTROSE Opening Spring 2009 Hours not fully defined, but will be similar to hours and functionality of Hudson location	*Trauma Level I Emergency Room: ___ Adult Beds / ___ Pediatric Beds *Licensed Beds: ___ Adult / ___ Newborn *Surge Beds: ___ No Burn Unit Pharmacy: 6am – 10pm Off-Site Facilities Summa has 9 satellite facilities located throughout Akron, Cuyahoga Falls, Green and Hudson which have a wide range of diagnostic capabilities, along with rehabilitation and physical therapy services.
AKRON GENERAL MEDICAL CENTER	**SUMMA HEALTH SYSTEM: BARBERTON HOSPITAL**
*Trauma Level I Emergency Room: ___ Adult Beds / ___ Pediatric Beds *Licensed Beds: ___ *Surge Beds: ___ No Burn Unit Pharmacy 24/7 Off-Site Facilities AKRON GENERAL HEALTH & WELLNESS CENTER NORTH Open 24/7 ___-bed Emergency Department No Overnight Stays No Pharmacy Capable of housing patients in a mass casualty situation	Not a Trauma Level Hospital Emergency Room: Adult Beds / Pediatric Beds *Licensed Beds: ___ *Surge Beds: ___ No Burn Unit Pharmacy 24/7 Off-Site Facilities No
CUYAHOGA FALLS GENERAL HOSPITAL	**ST. THOMAS HOSPITAL**
Not a Trauma Level Hospital Emergency Room: ___ Adult Beds / ___ Pediatric Beds *Licensed Beds: ___ *Surge Beds: ___ No Burn Unit Pharmacy 6am-10pm Off-Site Facilities No	Not a Trauma Level Hospital Emergency Room: ___ Adult Beds / ___ Pediatric Beds *Licensed Beds: ___ *Surge Beds: ___ No Burn Unit Pharmacy Open 21 Hours Off-Site Facilities No

Discipline: **HOSPITALS,** continued

DEFINITIONS

***Licensed Beds** refers to the maximum number of beds available in the hospital as permitted by state and federal law. The term **"staffed beds"** refers to the number of beds currently being used for inpatient use and care. (Example: Even though a hospital may be *licensed* for 500 beds, there may be only 400 patients in the hospital; therefore there are 400 *staffed* beds.)

***Surge Beds –** Maximum number of beds a hospital could create in a mass casualty situation

***Trauma Center - A** Trauma Center is equipped to provide emergency medical services 24/7 to patients suffering from traumatic injuries. To qualify as a trauma center a hospital must meet certain criteria:

A **Level I Trauma Center** provides the highest level of surgical care to patients. There must be a certain number of surgeons and anesthesiologists on duty at all times and staff physicians must have a variety of specialties including orthopedics, neurosurgery, emergency medicine, radiology, internal medicine, oral and maxillofacial surgery and critical care. Level I trauma centers must have outreach, education and research programs and be considered a regional referral resource. The American College of Surgeons designates these centers for a period of 3 years.

A **Level II Trauma Center** works in collaboration with a Level I center and provides comprehensive trauma care and supplements the clinical expertise of a Level I institution. No research or residency programs are required.

A **Level III Trauma Center** does not have full availability of specialists, but does have resources for emergency resuscitation, surgery and intensive care of most patients. Level III centers have transfer agreements with Level I or Level II centers that provide backup resources for the care of exceptionally severe injuries.

EXAMPLE

MATERIAL RESOURCES

All hospitals in Summit County operate with a 3-day, just-in-time inventory of supplies.

HUMAN RESOURCES RN=Registered Nurse • LPN=Licensed Practical Nurse • RT=Respiratory Therapist

Akron City Hospital ___RNs • ___ LPNs • ___RTs	**Akron Children's Hospital** ___RNs • ___LPNs • ___ RTs
Akron General Medical Center Approx. ___RNs and LPNs • Approx. ___RTs	**Summa/Barberton Hospital** ___ RNs • ___LPNs • ___ RTs
Cuyahoga Falls General Hospital ___ RNs • ___ LPNs • ___RTs	**St. Thomas Hospital** ___RNs • ___ LPNs • ___ RTs

NOTE: Most physicians, with the exception of those practicing at Children's Hospital, are NOT employees of the hospital.

ASSUMPTIONS

- Each hospital in Summit County will be able to provide information on how pandemic influenza is affecting their facility on a routine basis.
- Material resources at hospitals will quickly be exhausted due to just-in-time inventory for all hospitals across the United States.
- Standards of care will be based on the pandemic influenza situation at the time of the event for all Summit County hospitals.
- Each Summit County hospital has identified maximum surge capacity for their facility
- Just-in-time training will be utilized in different areas of providing care within the hospital setting
- There will be a shortage of hospital ventilators and ICU beds during a pandemic influenza. Pediatric ventilators will only be available at Akron Children's Hospital.
- Pediatric patients will present at all Summit County hospitals during a pandemic.
- Health care professionals from hospitals will not be available to staff alternate care sites.
- According to federal law, hospitals are required to evaluate and treat all patients who present at their facility.

EXAMPLE

SUMMIT COUNTY DISCIPLINE PROFILES

Discipline: **AT-RISK GROUPS**

DESCRIPTION

There are 75 agencies within Summit County providing services to individuals who fall within the "at-risk" category. The category is further divided into the following 5 groups:

- Physically/Mentally Disabled
- Geographically Displaced
- Aged (Elderly and Pediatric)
- Language Challenged
- Economically Disadvantaged

The information listed below was gathered from meetings with individual providers, and represents a **small sample** of at-risk providers in the county.

<table>
<tr><th colspan="3">COUNTY OF SUMMIT BUREAU OF MRDD</th></tr>
<tr>
<td rowspan="3">General Information:
• Provides services from birth to death for qualified developmentally disabled individuals
• Approximately ___ clients in Summit County
• Each client has a group of workers who meet at least once a year to review case status; more often if necessary
• Large number of private providers are utilized for therapy, transportation, daily living assistance, etc.
• BMRDD provides no direct residential services in group homes. Group homes are privately owned and occupants pay rent through Waiver services. Waiver providers are regulated through Ohio BMRDD.</td>
<td>Staffing:
• ___ staff
• Numerous private providers</td>
<td>Short-staff scenario:
• Teamwork, cross-training</td>
</tr>
<tr>
<td>Communication with clients:
• Quarterly mailing to clients and their families
• Yearly (or more often) meeting with caseworkers and clients</td>
<td>Pandemic plan?
• No pandemic plan in place at this time</td>
</tr>
<tr>
<td>Awareness of services:
• Referrals come primarily through schools and physicians</td>
<td>Miscellaneous:
• Disruption of group home residents' routines during a pandemic (i.e., staying home) may bring out other undesirable behaviors that will need to be addressed through home-based programming.</td>
</tr>
</table>

EXAMPLE

AREA AGENCY ON AGING

General Information:

- Serves homebound elderly and homebound disabled population
- Operates the PASSPORT program, which is designed to keep people in their homes instead of nursing homes
- 5013c organization receiving federal, state and local funding
- The four primary divisions within the agency are the Medicaid Managed Care Division, the Elder Rights Division, the Community Services Division, and the Planning and Quality Improvement Division
- 85% of resources are spent maintaining the Waiver program
- Coverage area is Summit, Stark, Portage and Wayne Counties

Staffing:

- Approximately ___ staff
- Network of ___ providers

Short-staff scenario:

- Prioritization
- A primary concern would be being able to pay their providers; if the providers don't get paid, there will be no services

Communication with clients:

- Constant outreach focused at their population
- AMHA and senior apartment buildings are good locations for disseminating information

Pandemic plan?

- Pandemic plan is in place

Awareness of services:

- Webpage
- Other social service agencies

Miscellaneous:

- Maintain list of nursing homes in Summit County

EXAMPLE

SUMMIT COUNTY CHILDREN'S SERVICES BOARD

General Information:

- Children are no longer housed at the main location on Arlington Street; that facility houses Intake, Administration and the Visitation Center.
- In 2007, ___calls of concern were received involving ___adults and ___children
- In 2007, ___child abuse/neglect investigations were conducted; ___% were substantiated
- In 2007, ___% of Intake clients were from Akron; ___% were from Barberton and ___% were from elsewhere in Summit Co.
- In 2007, ___children were served through substitute care placements (foster homes) ; ___children were placed in contracted placements

Other services include Protective Services, Kinship Services, Adoption Services, Independent Living and Transitional Housing .

Staffing:

- ___ staff

Short-staff scenario:

- Teamwork, cross-training
- Supervisors fill in when necessary

Communication with clients:

- Workers contact clients individually via cell phone

Pandemic plan?

- No pandemic plan in place at this time

Awareness of services:

- Levy awareness efforts
- Community forums, events
- Flyers in utility bills
- City buses
- Paper placemats in restaurants

Miscellaneous:

- Health care services are provided at the Thomas W. Blazey Diagnostic Center.

HAVEN OF REST

General Information:

- Shelter for homeless men at Haven of Rest; homeless women/children at Harvest Home – different facilities on the same campus. Open 24 hours a day, 365 days/yr
- ___ bed capacity; has been as high as ___ in winter, their peak season
- Different levels of sheltering (emergency, transitional, others – **Info Line can provide definitions of shelter types**)
- Length of stay depends on program involvement - can be up to 1 year
- In 2007, Haven of Rest provided ___meals ___nights of lodging, and ___pounds of clothing to individuals in need.
- Other homeless resources include CSS, Portage Path, Salvation Army, Battered Women's Shelter, Barberton Rescue Mission (New Destiny Treatment Center)
- **Info Line** maintains the Homeless Information Management System with information on all homeless facilities in the county, including up-to-the-minute capacity, statistics, and different levels of shelters available (emergency, transitional, etc.)

Staffing:

- ___ staff

Short-staff scenario:

- Teamwork, cross-training

Communication with clients:

- N/A

Pandemic Plan?

- Initial stages of developing plan

Awareness of services:

- Word of mouth
- Webpage
- Public awareness functions
- Info Line
- Churches
- Businesses
- Jails
- Other social service agencies

Miscellaneous:

EXAMPLE

SUMMIT COUNTY DEPARTMENT OF JOB AND FAMILY SERVICES

General Information:

- Operates 38 different Medicaid programs, including those that serve the disabled: MRDD, PASSPORT, Medicaid, Healthy Start, families at 200% of poverty level, refugees, victim assistance, others.
- Approximately ___families are enrolled in programming with a great deal of cross-enrollment.
- Approximately ___% of children in Summit County are on Medicaid.
- Approximately ___seniors are receiving services
- Approximately ___% of total population is served through some type of programming.
- Not for emergency services

Staffing:

- ___ staff

Short-staff scenario:

- Cross-training

Communication with clients:

- Quarterly mailings
- Townhouse meetings
- Client newsletter

Pandemic Plan?

- All-hazards plan in place

Awareness of services:

- Website
- Other social service agencies
- General awareness due to being a government agency
- Some marketing efforts

Miscellaneous:

<table>
<tr><th colspan="3">INFO LINE</th></tr>
<tr>
<td rowspan="3">General Information:
▪ 2-1-1 Call Center serves the general population through the I & R (Information and Referral) service, but Info Line also has some targeted programs.
▪ High percentage of consumers are low-income
▪ Operates Child Care Connection, the Homeless Information Management system, and LifeLine (___homebound elderly)
▪ Constant contact with over 1,200 service groups
• Blast fax and blast email capability</td>
<td>Staffing:
• ___ staff</td>
<td>Short-staff scenario:
• Cross-training
• Supervisors fill in when necessary</td>
</tr>
<tr>
<td>Communication with clients:
• N/A</td>
<td>Pandemic Plan?
• All-hazards plan in place</td>
</tr>
<tr>
<td>Awareness of services:
• Almost entirely word of mouth
• Website
• E-newsletter
• Other social service agencies</td>
<td>Miscellaneous:
• Call center typically has 10-12 phones manned, but has capacity for 30-40 lines. Consider using for “Pandemic Info Line.”</td>
</tr>
</table>

EXAMPLE

Proposed Summit County Alternative Care System Options (A Summary)

Adapted from "The Prospect of Using Alternative Medical Care Facilities in an Influenza Pandemic."

"Some investigators have suggested that the term *altered standards of care* is inappropriate and that a *standard of care appropriate to the situation that would optimize patient outcomes* is a more accurate and appropriate description" (Kaji, 2006).

1. **At-Home Independent Care:** This is self-sufficient independent care at home. From a public health as well as a medical perspective, Summit County will encourage self-isolation at home along with enhancing the ability of self-sufficient persons to do so. The general public may have questions and/or concerns, and need information on providing care at home. Persons may also need information on whether to go to the hospital, another care facility, or to remain at home. Risk communication to Summit County residents will be of paramount importance in empowering personal responsibility for these residents and/or their caregivers (Tadmor, 2006).

   Issues to consider: agencies that might be involved, triage, scope of care at this level, triggers, sources and coordination of information, resources needed, infection control.

2. **An Alternative Site for Isolation of Influenza Patients:** This is the "motel environment" for patients requiring minimal medical care. Alternative care facilities will be used to isolate infectious influenza patients based on the premise that it will be useful and possible to separate them from non-influenza patients. These sites will be intended to support patients who would otherwise remain at home but are unable to do so (e.g., they are unable to care for themselves; they are ill and share a residence with an immunocompromised individual). Food, laundry, and other living necessities will need to be provided to persons housed in these alternative care facilities.

   Issues to consider: private businesses who might be involved, number of facilities potentially needed, area that this would cover (e.g., just downtown or outlying areas of the county), triggers, scope of care, process of delivery of care, triage, overarching responsibility to whom, sources and coordination of information, resources needed, infection control.

3. **Expanded Role for Outpatient Care Facilities:** This concept ties in with the Neighborhood Emergency Help Center (NEHC), which is part of the Modular Emergency Medical System (MEMS). By utilizing existing outpatient facilities, this model may facilitate the rapid distribution of routine vaccines and medications, and treatment of minor injuries and illnesses (e.g., hydration) for both influenza and non-influenza patients.

   These sites will be used as triage sites to and from the hospital. This option might entail the use of outpatient surgery centers or hospital satellite facilities. It may be possible to cancel or postpone elective outpatient surgeries and testing procedures

during the peak waves in order to provide care to those in need of treatment, vaccinations, and/or medication.

Issues to consider: agencies/businesses that might be involved, identifying who is responsible for these centers, identifying current outpatient centers and bed counts/personnel, scope of care at this level, process of delivery of care, triggers, sources and coordination of information, resources needed, infection control, triage management/tool (on individual- or population-based care).

4. **Care for Recovering, Non influenza Patients:** This is the "step-down" method for patients not yet able to be discharged from the hospital to home. Recovering non-influenza patients may be discharged from the hospital to "step-down" facilities (e.g., long-term care [LTC], rehabilitation [rehab] facilities) until they are well enough to return home.

   Issues to consider: discharge for pandemic influenza patients or other recovering patients, e.g., orthopedic surgery, stable post-surgical patients; LTC facilities are private businesses; who would write medical orders; scope of care at this level; process of delivery of care; triggers, from where would reimbursement for these patients come; sources and coordination of information; resources needed; infection control.

5. **Rapid Patient Screening and Triage Inside the Hospital Emergency Department:** This is a take on the MEMS model. Persons seeking care will be screened and triaged at the hospital emergency department (ED).

   Patients in critical condition will be treated in hospitals, and those with non-critical illnesses and injuries will be transferred from the ED to an outpatient facility where treatment would be restricted to four areas: hydration, bronchodilators, antibiotics, and pain management.

   This model will need to be used in conjunction with Option 3—Expanded Role for Outpatient Facilities.

   Issues to consider: who would be responsible for providing care, location of alternative care centers (ACCs) (throughout the county or close to hospital EDs), level of triage, liability issues, scope of care, process of delivery of care, triggers, sources and coordination of information, resources needed, infection control, triage management/tool (on individual- or population-based care).

6. **Rapid Patient Screening and Triage Outside the Hospital Emergency Department:** This is a take on the MEMS model. All persons with influenza-like-illnesses (ILI) will be directed to primary triage sites for initial assessment. These sites will be set up physically separate from the hospital in order to minimize exposure of hospitalized patients to influenza. Critically ill patients will be transferred to hospitals. Non-critical patients will be discharged from the triage facility to home, provided with supportive care, or transferred to other healthcare facilities based on the community's established pandemic response protocol.

Issues to consider: location of triage sites, transportation issues from triage site to hospital or another level of care site, liability issues, scope of care, process of delivery of care, triggers, sources and coordination of information, resources needed, infection control, triage management/tool (on individual- or population-based care).

7. **<u>Mobile Hospital</u>:** This is similar to Carolinas MED-1. According to an article in the *Annals of Emergency Medicine,* "although the mobile facility should require space to treat critically ill or injured patients, the majority of the facility would be designed to address conventional emergency and ambulatory patients." (Blackwell, 2007) The Carolinas MED-1 unit cost approximately $1.5 million (using grant funds) and was utilized during the Katrina response.

   This model is also very similar to the standardized modular hospitals used by the U.S. Military.

   Issues to consider: responsibility, cost, liability issues, scope of care, process of delivery of care, sources and coordination of information, resources, infection control.

8. **<u>Overflow Hospital for Influenza Patients</u>:** This is similar to a model used in Pennsylvania during the 1918 pandemic. Based on the severe acute respiratory syndrome (SARS) incident "consideration should be given to designating specific hospitals as main centers for screening suspected cases and treating those affected: identifying hospitals to meet general and those to meet more specialized care needs of other critically ill patients." (Lawryluck, 2005)

   An overflow hospital will be set up to provide care for acutely ill influenza patients who would otherwise be admitted to the hospital. This site will replicate a full range of hospital services; however, those services provided may change as resource availability changes.

   http://www.annals.org/cgi/content/full/145/2/138

   Issues to consider: allocation and identification of a separate hospital in Summit County as "flu hospital," with acute care at identified hospitals; sections of existing hospitals as "flu floors;" scope of care; process of delivery of care; triggers; sources and coordination of information; resources needed; infection control.

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<table>
<tr><th colspan="2">Option 1: At-Home Independent Care</th></tr>
<tr><td colspan="2">Course of Action: The identified agencies will enhance the ability of self-sufficient persons and/or caregivers to continue independent care at home in order to decrease the surge on healthcare. They will help people determine when and how to stay home and when to seek outside care. To accomplish this course of action, the following sub-actions have to be taken:
_______________ (How) and _____________ (When) will this course of action will be initiated?</td></tr>
<tr><td>Who?</td><td>• Individuals: General Public, Worried Well, Ill (children and adults) and their family members
• Agencies: Public Health (PH), Private Care Providers (PCP), Home Health, Dispatch, Media, Hospital Emergency Departments (EDs), Faith-based Organizations, Outpatient Facilities, Urgent Care Centers, Occupational Health Clinics, Community Health Clinics, Information Centers/Lines (Summit County 2-1-1)</td></tr>
<tr><td>What?</td><td>• Increase the number of people who stay at home
• Enhance the ability for providing self-sufficient care at home (provide support services)
• Help persons determine whether to seek care at an outside facility</td></tr>
<tr><td>Where?</td><td>• Home</td></tr>
<tr><td>Why?</td><td>• To keep people out of the healthcare system
• Reduce the risk of getting or giving influenza</td></tr>
<tr><td>When?</td><td>• Multiple triggers, not just one, e.g.,
o Media driven
o Spike in Information Centers calls
o Spike in influenza-like illness (ILI) at the hospital
o Dependant on location
o Can be set up at the onset of pandemic
o PH/Emergency Management (EM) incident command system (ICS) driven</td></tr>
<tr><td>Assumptions</td><td>• People will stay at home
• People will be honest about their symptoms and situations
• Support services will not include direct medical care
• The scope of antiviral treatment is unknown (i.e., treatment, prophylaxis, or both)</td></tr>
</table>

How?	• Through media cooperation • Information provided by media and agencies must be consistent, reliable, and in real-time • Risk communication via media and online • Patient recordkeeping and tracking • Public education that encourages self-isolation should have been done pre-event • The identified agencies must have plans in place that have been trained and exercised • Coordinated effort between agencies and businesses • Primary triage information <u>may</u> come from the Summit County 2-1-1 Call Center, dispatch centers, or PCP offices. This triage support, through the Summit County 2-1-1 Call Center <u>may</u> be supplemented with public health personnel.

Advantages	Disadvantages
• Cost effective • Good infection control—keeps people at home and out of public places • Less burden on healthcare • Minimizes stress on first responders • Less stress on patients (familiar environment, caregivers, etc.) • Keeps people at home (social distancing) • Not reliant completely on medical staff (technology driven) • Anyone could be a home caregiver (mother, daughter, church members) • Decreases burden of worried well—provides consistent information	• Relies on patient honesty • No guarantee that people will actually stay at home • Providing support services could be taxing to identified agencies (i.e., antiviral distribution/delivery) • Call centers difficult to coordinate (technology/communication) • Technology driven—reliability? • Staffing call centers with individuals qualified to triage could be a problem • If phone based, what about people without phones (i.e., homeless) • How to monitor • Negative connotation of self-isolation/quarantine • Fatality management—added stress on families • Increased anxiety; therefore, need for mental health services • Legal issues

Resources and Tools (To be developed)
• Triage tool • Scripts for call centers • Antiviral distribution plan • Risk communication plan • Patient tracking/identification system • Memoranda of Agreement (MOA), Memoranda of Understanding (MOU), Mutual Aid Agreements (MAAs)

Option 2: An Alternative Site for Isolation of Influenza Patients	
Course of Action: __________ (Who) will separate influenza patients requiring minimal medical care who are unable to be cared for at home? To accomplish this course of action, the following sub-actions have to be taken: ________________ (How) and ______________ (When) will this course of action will be initiated?	
Who?	• Individuals: Influenza infected patients requiring minimal care, but who are unable to be supported at home. Patients who are exposed or ill that do not want to go home • Agencies: Public Health (PH), Private Care Providers (PCP), Home Health, Dispatch, Media, Hospital Emergency Departments, Faith-based Organizations, Urgent Care Centers, Occupational Health Clinics, Community Health Clinics, Information Centers/Lines (Summit County 2-1-1), homeless shelters, community-based organizations
What?	• Set up an alternative site to house and support influenza patients who require minimal medical care • This facility would be dedicated to isolating infectious influenza patients from non-influenza patients in hospitals and other healthcare facilities
Where?	• Motel, hotel, dorms, or similar bed facility, convention centers, camp sites, fairgrounds, school gyms, vacant buildings, closed military bases
Why?	• Minimize exposure of non infected people to influenza • Reduce surge to healthcare system from patients requiring minimal care, preserve critical services for severely ill

When?	• Multiple triggers, not just one, e.g.,
	  o Media driven
	  o Spike in Information Centers calls
	  o Spike in influenza-like illness (ILI) at the hospital
	  o Dependant on location
	  o Can be set up at the onset of pandemic
	  o PH/Emergency Management (EM) incident command system (ICS) driven

Assumptions	• People will be honest about their symptoms and situations • Businesses will be involved and will cooperate • Facilities will be provided only for minimal influenza care (supportive care) • Facilities will not be proved for quarantine • Critical infrastructure will continue to operate • Influenza patients can be housed together

How?	• Criteria will need to be determined for "ill and unable to be supported at home" (i.e., infected, symptomatic, share residence with an immuno-compromised individual, have developmental disability and/or ill family members, etc.) • Individuals will have to be directed to these alternative sites by call centers and media messaging • Establish a plan o Identify sites, scope of care, capabilities, staffing needs, needed resources, management requirements o Determine who approves, how to stand up, who runs it, reimbursement protocols o Identify and address legal issues, transportation services, security, recordkeeping and tracking o These plans must be trained and exercised • Obtain community buy-in • Establish MOU/MOA/MAAs with businesses to provide facility, resources, etc. • Establish relationships with volunteer and other agencies to assist with staffing/support • Public education should be conducted pre-event: o Legal issues during a PH disaster (regarding isolation) • Infection control (i.e., risk to immuno-compromised)

Advantages	Disadvantages
• Easy to bring up and scale down (flexible) • Easy to return facility to former use • Can use non-medical personnel/volunteers • Fewer resources required • More cost effective than full-service • Good facilities for minimal care secure, accessible, basic infrastructure in place, isolated rooms • Less burden on healthcare • Keeps infected people out of the hospital, away from non-infected or immuno-compromised patients • Right thing to do (ethical) • Reduces transmission to medically fragile • Gives and alternative to home care for those that live alone • Efficient use of resources	• Stigma for facilities • Media nightmare • Compensation/reparations to businesses/staff • Security • Negative connotation of isolation/ quarantine • No existing structure (personnel, supplies) • Non-infected travelers in hotel (?) • Not staffed by medical personnel—what happens if someone requires acute care? • Staffing • Legal issues • Reimbursement issues • Getting buy-in and establishing agreements with businesses (time consuming/coordination) • Infection control • Recordkeeping/tracking • Huge differences between jurisdictions

Resources and Tools (To be developed)	
• Triage Tool (additional sheet) • Volunteer Registry • MOU/MOA/MAAs	• Risk Communication Plan • Alternative Care System Plan • Patient Recordkeeping/Tracking System)

Option 3: Expanded Role for Outpatient Care Facilities	
Course of Action: Existing outpatient facilities will provide care to patients with minor injuries and illnesses in order to preserve critical hospital resources for the most severe patients. To accomplish this course of action, the following sub-actions have to be taken: _______________ (How) and _____________ (When) will this course of action will be initiated?	
Who?	• Individuals: patients with minor injuries and illnesses seeking care and those seeking medication (to include routine distribution of vaccine and possibly antivirals) • Agencies: Existing outpatient, walk-in, and ambulatory care facilities, Public Health (PH), Private Care Providers (PCP), Emergency Management (EM), hospitals, Neighborhood Emergency Help Center (NEHC), which is part of the Modular Emergency Medical System (MEMS)
What?	• Support and manage patients with minor injuries and illnesses, to include distribution of routine medication and vaccines, hydration, intravenous antibiotics, and short-term symptom monitoring • These facilities may also be used as triage sites to and from the hospital
Where?	• Existing facilities
Why?	• Redirect the surge on the healthcare system and hospitals in order to preserve critical services for the severely ill • Support patients with minor injuries and illnesses outside of the hospital • Facilitate the distribution of vaccines and medications outside of the hospital
When?	• Multiple triggers, not just one, e.g., o Media driven o Spike in Information Centers calls o Spike in influenza-like illness (ILI) at the hospital o Dependant on location o Can be set up at the onset of pandemic o PH/Emergency Management (EM) incident command system (ICS) driven
Assumptions	• Providers and existing facilities will agree to these roles • The role of the out patient clinic in antiviral distribution and treatment is unknown (i.e., treatment, prophylaxis, or both)

<table>
<tr><td>How?</td><td>

- Through media cooperation
- Criteria will need to be determined for these patients (e.g., acute patients will need to be triaged to centers providing critical care)
- Individuals will have to be directed to these triage sites by call centers and media messaging
- Public education should have been done pre-event
- Establish MOU/MOA/MAAs with outpatient clinics to provide staff/facility
  - Must be included in clinic plans, particularly if services will be disrupted (e.g., elective procedures cancelled)
- Agencies must support facilities and direct patients to/from facility
- Plans for these facilities must be trained and exercised
- Staff roles must be expanded
- Facility roles expanded (e.g., 24-hour operation)
- Redirect maternity patients to women's centers
- Transportation of patients

</td></tr>
</table>

Advantages	Disadvantages
• Keeps non-acute people out of the hospital and from calling 9-1-1/EMS • Gives patients adequate level of care (IV, fluids, etc.)→keeps patients happy and out of ED/9-1-1 • Trained staff already in place • Cost effective—utilizes existing infrastructure • Reimbursement issues are "less sticky" • Patient recordkeeping/tracking is easier • Using an existing system • Logistics are easier • Reduced just-in-time training needs • Quicker treatment	• Criteria for who should go to this facility—can patients determine whether they are acutely ill • Security • Infection Control—in waiting room • Could be taxing on transport, particularly if multiple facilities are used • Added stress on staff • Added levels of care • Handle high volume?? • Parking??

Resources and Tools (To be developed)
• Risk Communication Plan • Infection Control Plan • MOU/MOA/MAAs

Option 4: Care for Recovering, Non Influenza Patients	
Course of Action: Non influenza patients, not ready to be sent home, will be discharged from the hospital and transferred to "step-down" facilities (e.g., long-term care [LTC], rehabilitation [rehab] facilities To accomplish this course of action, the following sub-actions have to be taken: ______________ (How) and ____________ (When) will this course of action will be initiated?	
Who?	• Individuals: Non influenza patients, not yet ready for home discharge • Agencies: LTC and Rehab Facilities, Hospitals, Home Health, Surgery Clinics, Outpatient Facilities, Women's Centers, Specialized Care Facilities, e.g., Ear, Nose, and Throat
What?	• Discharge non influenza patients from the hospital to an alternative site providing "step-down" care
Where?	• "Step-down" facilities
Why?	• Free up hospital beds • Serve as a "step-down" unit for recovering non influenza patients • Separate non influenza patients from influenza patients in the hospital
When?	• Spike in flu cases in the hospital • Decrease in available beds in hospital • Increase in the need for hospital beds
Assumptions	• Facilities will: o cooperate (willing to take patients) o have space available o be willing and able to expand their role beyond usual capacity and capabilities • Facilities' staff will be willing and able to expand their role • Medical transportation for these patients is available • Patients/families will be able and willing to move

<table>
<tr><td>How?</td><td colspan="2">

- Establish criteria for the discharge of “non infected patients not yet ready for home discharge”
- Establish MOU/MOA/MAAs with "step-down" facilities and transport services to provide staff/resources/facility
  - Determine appropriate sites taking into account their capacity and capability
  - Must be included in agency plans, particularly if services will be disrupted (e.g., elective procedures cancelled, non-critical patients no longer transported)
- Through media cooperation
- Information provided by media and agencies must be consistent, reliable, and in real-time
- Risk communication via media and online
- Patient recordkeeping and tracking
- Patients will need to be “qualified,” then transported
- Agencies will support facilities and direct patients to/from facility
- Public education (before and during the event)
- Plans for these facilities must be trained and exercised
- "Just-in-time" training for the "step-down" facilities' staff

</td></tr>
<tr><th colspan="2">Advantages</th><th>Disadvantages</th></tr>
<tr><td colspan="2">

- Keeps influenza and non-influenza patients separate, infection control
- Infrastructures in place (facility, staff)
- Frees hospital staff and beds for flu patients
- More cost-effective to patients (?)
- Supply chain in place
- Increase hospital bed availability
- Reduce burden on outpatient care facilities
- Immediate solution
- Time consuming (spend a lot of time analyzing capabilities)

</td><td>

- How can you ensure patients have not been infected in the hospital and then infecting patients in the new facility?→Infection Control
- Burdensome on transport services
- Patient tracking→lots of movement
- Reimbursement
- Who writes the medical orders?
- Available staff may not be qualified to treat more advanced patients (dependant on medical director)
- Confusing, stressful on families
- Quality of care
- Legal issues
- Standing orders in LTC facilities
- Preparedness planning in "step-down" facilities
- Medical supervision
- Education dependent

</td></tr>
<tr><th colspan="3">Resources and Tools
(To be developed)</th></tr>
<tr><td colspan="2">

- Triage Tool
- MOU/MOA/MAAs
- Transport Plans
- Risk Communication Plan

</td><td>

- Media Messaging
- "Just-in-time" Training
- Infection Control Plan

</td></tr>
</table>

Option 5: Rapid Patient Screening and Triage Inside the Hospital Emergency Department

Course of Action: Hospitals will use their emergency department (ED) to screen and triage patients seeking care in order to determine their course of treatment (i.e., hospitalization versus outpatient care). To accomplish this course of action, the following sub-actions have to be taken:
_____________ (How) and ___________ (When) will this course of action will be initiated?

Who?	• Individuals: All patients entering hospital ED • Agencies: Hospital EDs; existing outpatient, walk-in, and ambulatory care facilities; Public Health (PH); Private Care Providers (PCP); Emergency Management (EM); dispatch centers; mental health; Neighborhood Emergency Help Center (NEHC), which is part of the Modular Emergency Medical System (MEMS)
What?	• Primary triage of patients in the ED (separate into critical and non critical) • Critical patients treated in hospital • Non critical transported to outpatient facilities
Where?	• Hospital EDs • Outpatient facilities
Why?	• Redirect the surge on the healthcare system and hospitals in order to preserve critical services for the severely ill
When?	• Multiple triggers, not just one, e.g., o Media driven o Spike in Information Centers calls o Spike in influenza-like illness (ILI) at the hospital o Dependant on location o Can be set up at the onset of pandemic • Must coexist with Option 3
Assumptions	• Criteria will be established to define “critical versus non critical” • Additional staff will be required • Public education will be conducted prior to event • Transportation is available for transferring noncritical patients to acute care centers • There is space available in the hospital for critical patients • Acute care facilities are available to care for non acute patients • Consistent messaging will be available; media will cooperate • Option can only be implemented if combined with Option #3 (Expanded Role for Outpatient Care Facilities)

How?	• Triage criteria and protocols will be established to rapidly define "critical versus non critical" • Public education will be conducted prior to event • Emergency department staff and additional support agencies will triage patients to hospital or outpatient facility • Rapid triage • Suspend Emergency Medical Treatment and Active Labor Act (EMTALA) • Coordinated effort between all facilities (including outpatient facilities for Option #3) • Facilities in all communities implement at the same time • Just-in-Time staff training for rapid triage protocols • Create a plan for additional staff

Advantages	Disadvantages
• Easier to understand • Easily accessible→familiar • Healthcare has greater control • Many patients will provide own transport • Easier for families to stay together • Not burdened by support services—not providing meals and beds • Reduction in patient admissions • Reserves hospital resources for most severe patients • Decreases wait time for non-acute in ED • Transport logistics are simpler—one way • Potentially const effective (cheap tent) • Logistics simpler • Keeps chaos away from in-patient hospital and healthcare facilities	• Increased burden on Infection Control • Sustainability—will this require a change in criteria for critical patients as hospital beds decrease? • Increased surge on ED (space and resources) • Security/managing panic • Patient compliance with orders (second opinion?) • Potential lack of reimbursement • Relies on patient honesty • Record keeping and tracking difficult • ILI symptoms are not concrete • Teaching staff new triage protocols • Criteria may need to be revised for sustainability • Not a stand alone option—must be combined with Option #3 • Ethical concerns • Staffing

Resources and Tools (To be developed)
• Rapid Triage Tool (individual based- population-based care) • Risk Communication Plan • Hospital Plan • Mental Health Support Plan

Option 6: Rapid Patient Screening and Triage Outside the Hospital Emergency Department

Course of Action: __________ (Who) will set up primary triage sites to minimize exposure of hospitalized patients to influenza? To accomplish this course of action, the following sub-actions have to be taken:
______________ (How) and ____________ (When) will this course of action will be initiated?

Who?	• Patients: All patients with influenza-like illness (ILI) • Agencies: Public Health (PH), Private Care Providers (PCP), Home Health, Dispatch, Media, Hospital Emergency Departments (EDs), Faith-based Organizations, Outpatient Facilities, Urgent Care Centers, Occupational Health Clinics, Community Health Clinics, Information Centers/Lines (Summit County 2-1-1)
What?	• Rapid screening and assessment of ILI symptoms • Critical patients sent to ED • Non critical patients discharged to home, provided with supportive care, or transferred to another healthcare facility based on pandemic response protocols
Where?	• Physically away from hospital EDs—(Sites need to be determined)
Why?	• Minimize exposure of non infected patients to influenza • Control entry of ILI patients into the healthcare system • Effectively direct patients to appropriate care
When?	• Multiple triggers, not just one, e.g., o Media driven o Spike in Information Centers calls o Spike in influenza-like illness (ILI) at the hospital o Dependant on location o Can be set up at the onset of pandemic o PH/Emergency Management (EM) incident command system (ICS) driven
Assumptions	• Transport to/from facilities will be available • There is space available in the hospital for critical patients • People will be honest about their symptoms and whether they are experiencing ILI symptoms • People will go where they are directed • There will be space and equipment for triage sites • Staff will be available to stand up the site

How?	• Through media cooperation • Information provided by media and agencies must be consistent, reliable, and in real-time • Public education that encourages self-isolation should have been done pre-event • Established MOU/MOA/MAAs with agencies/businesses to provide facility, staff, supplies • Direct all patients with influenza like illness to primary triage site • Using triage tool, determine critical versus non critical • Critical patients sent to hospital • Non critical patients sent home, provided supportive care, or transferred to an alternate facility

Advantages	Disadvantages
• Straightforward to understand • Easily accessible • Many patients will provide own transport • Easier for families to stay together • Reduction in hospital admissions • Reserves hospital resources for most severe patients • Could be cost effective • Public health and healthcare have greater control • Gives a coordinated look at access • Keeps chaos away from healthcare facilities • Transportation logistics are simpler one-way	• Triage site burdened by worried well (potential exposure to infected patients) • Security nightmare • Staffing • Potential lack of reimbursement (may be a disadvantage) • Transport—being away from hospital, critical patients (and potentially non-critical) may need to be transported • Traffic/Public Safety issues associated with having large numbers of people all going to one place • Recordkeeping and tracking difficult • Criteria may need to be revised for sustainability • Different from the norm • ILI symptoms are not concrete

Resources and Tools (To be developed)
• Triage (patient management) tool • Risk Communication Plan • Alternative Care Facility (ACF) site plan • MOU/MOA/MAA template

Option 7: Mobile Hospital	
Course of Action: ___________ (Who) will set up a mobile field hospital designed to treat critically ill patients? The facility will be dedicated to addressing conventional emergency and ambulatory patients, while some space can be dedicated to treat the critically ill or injured. To accomplish this course of action, the following sub-actions have to be taken: ______________ (How) and ____________ (When) will this course of action will be initiated?	
Who?	• Patients: Acutely-ill patients requiring traditional emergency care that would typically be treated in the hospital • Agencies: Emergency Management (EM), Hospital Association, Mobile Hospital Team
What?	• Set up mobile field hospital • Provide care for moderate to severe patients
Where?	• Specific site TBD (requires large, open area—field, stadium, fairgrounds, parking lot, etc.)
Why?	• To decrease the surge on the healthcare system
When?	• Multiple triggers, not just one, e.g., o Media driven o Spike in Information Centers calls o Spike in influenza-like illness (ILI) at the hospital o Dependant on location o Can be set up at the onset of pandemic o PH/Emergency Management (EM) incident command system (ICS) driven
Assumptions	• Individuals will have to be directed to these triage sites by call centers and media messaging • Federal assets, the Commission Corps, and military assets will not be available • Transport to these facilities will be available

How?	• Through media cooperation • Information provided by media and agencies must be consistent, reliable, and in real-time • Acquire funding • Reimbursement • Field hospital will have infrastructure to treat acutely ill patients • Determine scope of care provided by Mobile Hospital • Purchase hospital and related equipment • Establish MOU/MOA/MAAs for staffing, facility, and supplies • Plan, train, and exercise • Establish triage protocols for mobile hospital and transport services (EMS)

Advantages	Disadvantages
• Keep a few people out of the general healthcare system/hospitals • Keep a few people out of the public • Equipped to provide more advanced care to acute patients (then typical out-patient centers or other types of ACF) • Put it anywhere there is a large space • Quickly mobilized • Can be used for other responses	• May be cost prohibitive for number of beds freed in the hospital • Not much capacity for the cost of resources required • Staffing issues—may take staff from other facilities • Security • Length of time for capacity—sustainability • Infection control if housing flu and non flu together • Has to be maintained • Has to be Joint Commission (JC) compliant (pre-approval required) • Reimbursement may be difficult • What to do when not in use • Storage, upkeep, and maintenance costs

Resources and Tools (To be developed)
• Mobile Field Hospital Plan • MOU/MOA/MAAs • Risk Communication Plan • Training for staff

Option 8: Overflow Hospital for Influenza Patients	
Course of Action: ___________ (Who) will set up and provide care for acutely ill influenza patients who would otherwise be admitted to the hospitals? These alternative care facilities (ACFs) would replicate a full range of hospital services (these would need to be determined as well as based on resources that may or may not be available). To accomplish this course of action, the following sub-actions have to be taken: ______________ (How) and ____________ (When) will this course of action will be initiated?	
Who?	• Patients: Patients with pandemic influenza who are acutely ill and require a range of hospital services (e.g., pulmonary support) • Agencies: Public Health (PH), Private Care Providers (PCP), Home Health, Dispatch, Media, Hospital Emergency Departments (EDs), Faith-based Organizations, Urgent Care Centers, Occupational Health Clinics, Community Health Clinics, Information Centers/Lines (Summit County 2-1-1)
What?	• Designate or set up "flu-hospitals" for suspected cases • Provide acute-care to influenza patients, based on standards of care appropriate to the situation and available resources
Where?	• Closed hospital or other acute care facilities—TBD (Shuttered hospitals, closed military base)
Why?	• To separate acutely ill influenza and non influenza patients

When?	• Must be decided early in order to implement
	• Multiple triggers, not just one, e.g.,
	  o Media driven
	  o Spike in Information Centers calls
	  o Spike in influenza-like illness (ILI) at the hospital
	  o Dependant on location
	  o Can be set up at the onset of pandemic
	  o PH/Emergency Management (EM) incident command system (ICS) driven

Assumptions	• People will be honest about their symptoms and situations • Business and the media will be involved and will cooperate • The overflow facilities will be provided only for patients with influenza-like illness (ILI) symptoms

How?	• In essence, this option involves all taking all the steps necessary to set up a hospital—financial, legal, structural, etc. (lengthy process) • Establish MOU/MOA/MAAs with hospitals/other care facilities/suppliers to provide facility, staff, resources o Must be incorporated into facility plans, particularly if patient services will be altered (i.e., must determine where to send non influenza patients in the facility) • Plan, train, and exercise plans • Develop plan/media tools to direct patients to the appropriate location • Develop plans for acquiring and/or redirecting resources (e.g., staff, supplies, equipment) • Initial triage criteria/protocol must be created • If non hospital, acquire appropriate accreditation to function as a hospital facility • "Just-in-time" training for staff

Advantages	Disadvantages
• Keep people out of the general healthcare system • Keep ill patients out of the public • Keep ILI and non ILI patients apart	• Cost prohibitive (?) • Staffing issues—may take staff from existing facilities • Security • Length of time for capacity • Not workable—how to determine if ILI is influenza or not • Need initial triage criteria/protocol to quickly determine who is and is not infected with influenza o ILI symptoms are not concrete, may be difficult to triage • Have to redirect supply chain • Staff need to be trained • Opening a new hospital from scratch • Reimbursement may be difficult • Stigma—"flu hospital" • Accreditation of hospitals is required • Patients may have been exposed to influenza before entering non-influenza hospital—not a fool-proof infection control method

Resources and Tools (To be developed)	
• Risk Communication Plan • "Just-in-time" Training Materials	• ACS Hospital Plan • MOU/MOA/MAAs

Regional Workshop III
with
Summit County, Ohio

Pandemic Influenza Planning
for a
Community Alternative Care System

AGENDA

Sponsored by
Centers for Disease Control and Prevention
Division of Healthcare Quality Promotion

Conducted by
Oak Ridge Institute for Science and Education

at the
Chautauqua Suites Meeting & Expo Center
Mayville, New York

September 23 – 25, 2008

DAY I
Tuesday, September 23, 2008

Time	Activity	Presenter
7:00 a.m. to 8:00 a.m.	**CONTINENTAL BREAKFAST, Registration, and Networking**	
8:00 a.m. to 9:15 a.m.	Welcome	
	• Safety announcement..	Linda Hodges
	• Welcoming Remarks (ORISE)	Freddy Gray
	– Introductions	
	• Welcoming Remarks (CDC)	Deborah Levy
	– Introductions	
	– Acknowledgements	
	• Summit County Participant Introductions	Linda Hodges
	• Workshop Overview	Linda Hodges
	– Purpose	
	– Goal	
	– Objectives	
	– Agenda	
	– Instructions	
	• Administrative announcements...........................	Linda Hodges
	• Questions?	
9:15 a.m. to 10:45 a.m.	Introduction to Pandemic Influenza	Kerry Kernen
	Introduction to Emergency Management..................	Annette Petranic
	Community Workshops	
	Background	Annette Petranic
	Presentations	Annette Petranic
	• Workshop #1, Dispatch	
	• Workshop #3, Law Enforcement	
	• Workshop #4, Fire and Emergency Medical Services	
	• School Assumptions	
10:45 a.m. to 11:00 a.m.	**BREAK**	

DAY I continued
Tuesday, September 23, 2008

Time	Session	Presenter
11:00 a.m. to 12:00 noon	Presentations, continued	Kerry Kernen
	• Workshop #2, Public Health	
	• Workshop #5, Special Needs	
	• Workshop #6, Healthcare	Marianne Lorini
	• Long-Term Care Facility Assumptions	
	• Hospital Assumptions	
12:00 noon to 12:15 p.m.	Other Assumptions	
	• State Assumptions	TBD
	• Federal Assumptions..	Deborah Levy
12:15 p.m. to 1:15 p.m.	**WORKING LUNCH**	
1:00 p.m. to 1 45 p.m.	Activity... Discussion based on the Healthcare System Patient Gateways flowing into an ACS	Linda Hodges
1:45 p.m. to 2:00 p.m.	Scenario...	Kerry Kernen
2:00 p.m. to 2:30 p.m.	Alternative Care System (ACS) Options	
	Overview	Kerry Kernen
2:30 p.m. to 2:50 p.m.	**BREAK** and Move to break-out rooms	
2:50 p.m. to 4:20 p.m.	Breakout Sessions ACS Options 1 and 2 discussions	
4:20 p.m.	Move to plenary room	
4:20 p.m. to 4:25 p.m.	Wrap-up Day 1	Linda Hodges
4:25 p.m. to 4:30 p.m.	Overview Day 2	Linda Hodges
4:30 p.m.	**ADJOURN**	

DAY II

Wednesday, September 24, 2008

7:00 a.m. to 7:45 a.m.	**CONTINENTAL BREAKFAST and Networking**
7:45 a.m. to 8:00 a.m.	Move to break-out rooms
8:00 a.m. to 9:30 a.m.	Breakout Sessions ACS Options 3 and 4 facilitated discussions
9:30 a.m. to 9:45 a.m.	**BREAK**
9:45 a.m. to 11:15 a.m.	Breakout Sessions, continued ACS Options 5 and 6 facilitated discussions
11:15 a.m.	Move to plenary room
11:30 a.m. to 12:45 p.m.	**WORKING LUNCH**
12:45 p.m. to 2:15p.m.	Breakout Sessions, continued ACS Options 7 and 8 discussions
2:15 p.m. to 2:30 p.m.	**BREAK**
2:30 p.m. to 3:30 p.m.	Legal Presentation.. Evan D. Anderson, J.D. with a Question and Answer Session
3:30 p.m. to 3:45 p.m.	Wrap-up Day 2 .... Linda Hodges
3:45 p.m. to 4:00 p.m.	Overview Day 3 .... Linda Hodges
4:00 p.m.	**ADJOURN**

DAY III

Thursday, September 25, 2008

Time	Session	Presenter
7:00 a.m. to 7:45 a.m.	**CONTINENTAL BREAKFAST and Networking**	
8:00 a.m. to 10:00 a.m.	ACS Options Discussion Summation	Breakout Facilitators
10:00 a.m. to 10:15 a.m.	**BREAK**	
10:15 a.m. to 10:45 a.m.	ACS Options Decision Briefing	Kerry Kernen
10:45 a.m. to 11:30 a.m.	Summit County ACS Options Decision.....................	Kerry Kernen
11:30 a.m. to 12:00 noon	Concluding Remarks	
	• Summit County..	Kerry Kernen
	– Next Steps	
	– Future timeline	
	– Who will move this forward?	
	• CDC..	Deborah Levy
	• ORISE	Linda Hodges
	– Participant Evaluation	
	– Hot Wash	
	– Next Steps	
	– Future timeline	
	– How do we stay in touch?	
	– How will we assist further?	
	– Who will move this forward?	
12:00 noon	**WORKSHOP ADJOURNS**	

ATTACHMENT 6: ALTERNATIVE CARE SYSTEM WORKSHOP PARTICIPANT NOTEBOOK

Three-ring binders were prepared for the participants containing the following information:

- Summit County Community Profiles –*page 68-72*
- Discipline Profiles –*Attachment 2, pages 31-39*
- Options Document –*Attachment 3, pages 40-45*
- Copies of the PowerPoint presentations –*pages 73-82*
- Evaluation tools –*pages 83-86*
- Agenda –*Attachment 5, pages 62-66*
- Comment cards –*page 87*
- Goals and objectives –*Attachment 1, page 30*
- Community maps
- Reference documents, including a glossary of terms from www.pandemicflu.gov and a list of frequently used acronyms
- Participant list with name, agency and contact information of participant
- Reimbursement paperwork

Civilian Labor Force

	2002	2003	2004	2005	2006
Civilian labor force	281,200	283,700	286,800	290,200	294,200
Employed	264,400	266,200	269,500	273,500	278,600
Unemployed	16,800	17,500	17,400	16,700	15,600
Unemployment rate	6.0	6.2	6.1	5.7	5.3

Employment and Wages by Sector

	Average Annual Employment		Total Wages (in thousands of dollars)	
NAICS Industrial Sector	2004	2005	2004	2005
Total covered under Ohio UC Law	262,417	267,988	$9,778,436	$10,197,524
Private Sector	233,463	239,681	$8,633,428	$9,039,230
Agriculture, forestry, fishing and hunting	193	190	$5,465	$5,662
Mining	87	103	$16,165	$9,568
Utilities	2,282	2,174	$159,870	$179,175
Construction	11,008	10,975	$427,719	$433,859
Manufacturing	37,374	37,023	$1,828,748	$1,781,088
Wholesale trade	12,924	14,139	$631,874	$748,956
Retail trade	33,291	33,034	$836,048	$790,860
Transportation and warehousing	7,116	8,301	$306,790	$361,628
Information	4,052	3,952	$187,730	$187,475
Finance and insurance	9,614	9,775	$459,055	$465,043
Real estate and rental and leasing	3,019	3,097	$83,093	$89,350
Professional and technical services	10,752	11,183	$532,574	$584,753
Management of companies and enterprises	11,914	13,213	$883,268	$1,067,714
Administrative and waste services	17,497	18,085	$417,381	$391,412
Educational services	3,546	3,485	$83,989	$85,961
Health care and social assistance	35,310	36,738	$1,292,678	$1,367,102
Arts, entertainment, and recreation	3,729	3,786	$61,141	$61,256
Accommodation and food services	21,358	21,814	$239,880	$244,515
Other services, except public administration	8,397	8,617	$179,960	$183,853
State and Local Government	28,955	28,307	$1,145,008	$1,158,294
State government	4,552	4,707	$208,026	$218,983
Local government	24,403	23,600	$936,982	$939,311
Federal Government	2,560	2,351	$125,489	$119,389

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Business Numbers

	2002	2003	2004	2005	2006
Business starts	1,237	1,437	1,087	1,103	1,269
Active businesses	11,895	11,997	12,037	12,051	12,119

Residential Construction

	2002	2003	2004	2005	2006
Total units	2,073	2,354	2,223	1,968	1,628
Total valuation (000)	$327,212	$360,772	$364,346	$350,233	$275,253
Total single-unit bldgs	1,623	1,929	1,828	1,685	1,229
Average cost per unit	$181,896	$176,568	$189,005	$199,914	$209,434
Total multi-unit bldg units	450	425	395	283	399
Average cost per unit	$71,101	$47,464	$47,707	$47,271	$44,757

Major Employers

Employer	Sector
Akron City Bd of Ed	Govt
Akron General Health System	Serv
Children's Hospital Medical Center	Serv
Chrysler LLC	Mfg
Diebold Inc	Mfg
FirstEnergy Corp	Utility
Goodyear Tire & Rubber Co	Mfg
Jo-Ann Stores Inc	Trade
McDermott Int'l/Babcock & Wilcox	Mfg
Signet Group plc/Sterling Inc	Trade
Summa Health System	Serv
University of Akron	Govt

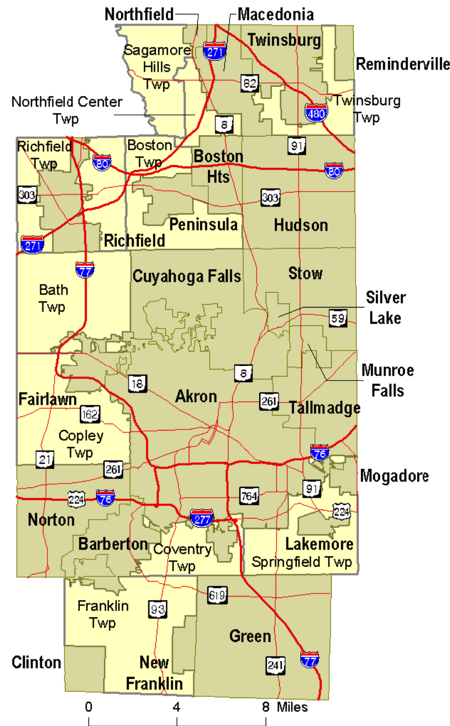
Ohio County Profiles

Prepared by the Office of Strategic Research

Ohio Department of Development

Summit County

Established: Act - March 3, 1840
2006 Population: 545,931
Land Area: 412.8 square mile
County Seat: Akron City
Named for: Highest point along the Erie-Ohio Canal



Taxes

Taxable value of real property	$11,750,050,340
Residential	$9,053,985,410
Agriculture	$102,230,830
Industrial	$360,969,710
Commercial	$2,229,658,710
Mineral	$3,205,680
Ohio income tax liability	$459,052,483
Average per return	$1,823.55

Land Use/Land Cover

	Percent
Urban (Residential/Commercial/Industrial/ Transportation and Urban Grasses)	46.93%
Cropland	4.81%
Pasture	1.97%
Forest	41.13%
Open Water	1.77%
Wetlands (Wooded/Herbaceous)	3.01%
Bare/Mines	0.38%

Largest Areas

	Census 2000	Est. 2006
Akron city	217,074	209,704
Cuyahoga Falls city	49,374	50,398
Stow city	32,139	34,335
Barberton city	27,899	27,063
Green city	22,817	23,532
Hudson city	22,439	23,154
Twinsburg city	17,006	17,484
Tallmadge city	16,180	17,119
Springfield twp	15,168	15,418
New Franklin village	2,191	15,013

UB: Unincorporated Balance

Total Population

Census

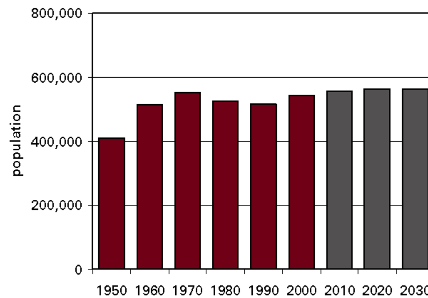
1800		**1900**	71,715
1810		**1910**	108,253
1820		**1920**	286,065
1830		**1930**	344,131
1840	22,560	**1940**	339,405
1850	27,485	**1950**	410,032
1860	27,344	**1960**	513,569
1870	34,674	**1970**	553,371
1880	43,788	**1980**	524,472
1890	54,089	**1990**	514,990
		2000	542,899

Estimated

2001	545,419
2002	546,149
2003	546,298
2004	546,366
2005	546,285
2006	545,931

Projected

2010	557,660
2020	564,810
2030	564,210



Population by Race

Population by Race	Number	Percent
Total Population	542,899	100.0%
White	452,810	83.4%
African-American	71,120	13.1%
Native American	1,184	0.2%
Asian	7,735	1.4%
Pacific Islander	144	0.0%
Other	1,777	0.3%
Two or More Races	8,129	1.5%
Hispanic (may be of any race)	4,491	0.8%
Total Minority	92,532	17.0%

Population by Age

Population by Age	Number	Percent
Total Population	542,899	100.0%
Under 6 years	43,099	7.9%
6 to 17 years	92,902	17.1%
18 to 24 years	44,253	8.2%
25 to 44 years	161,502	29.7%
45 to 64 years	124,398	22.9%
65 years and more	76,745	14.1%
Median Age	37.2	

Educational Attainment

Educational Attainment	Number	Percent
Persons 25 years and over	362,645	100.0%
No high school diploma	51,876	14.3%
High school graduate	121,705	33.6%
Some college, no degree	78,808	21.7%
Associate degree	19,160	5.3%
Bachelor's degree	60,675	16.7%
Master's degree or higher	30,421	8.4%

Family Type by Presence of Own Children Under 18

Family Type by Presence of Own Children Under 18	Number	Percent
Total Families	145,058	100.0%
Married-couple families with own children	48,445	33.4%
Male householder, no wife present, with own children	4,075	2.8%
Female householder, no husband present, with own children	15,518	10.7%
Families with no own children	77,020	53.1%

Family Type by Employment Status

Family Type by Employment Status	Number	Percent
Total Families	145,058	100.0%
Married couple, husband and wife in labor force	60,055	41.4%
Married couple, husband in labor force, wife not	24,299	16.8%
Married couple, wife in labor force, husband not	6,624	4.6%
Married couple, husband and wife not in labor force	20,021	13.8%
Male householder, in labor force	6,178	4.3%
Male householder, not in labor force	1,653	1.1%
Female householder, in labor force	17,418	12.0%
Female householder, not in labor force	8,810	6.1%

Poverty Status in 1999 of Families By Family Type by Presence Of Related Children

Poverty Status in 1999 of Families By Family Type by Presence Of Related Children	Number	Percent
Total Families	145,058	100.0%
Family income above poverty level	134,162	92.5%
Family income below poverty level	10,896	7.5%
Married couple, with related children	1,500	13.8%
Male householder, no wife present, with related children	614	5.6%
Female householder, no husband present, with related children	6,725	61.7%
Families with no related children	2,057	18.9%

Ratio of Income in 1999 To Poverty Level

Ratio of Income in 1999 To Poverty Level	Number	Percent
Population for whom poverty status is determined	533,162	100.0%
Below 50% of poverty level	24,101	4.5%
50% to 99% of poverty level	28,890	5.4%
100% to 149% of poverty level	35,610	6.7%
150% to 199% of poverty level	41,619	7.8%
200% of poverty level or more	402,942	75.6%

Household Income in 1999

Household Income in 1999	Number	Percent
Total Households	217,865	100.0%
Less than $10,000	19,044	8.7%
$10,000 to $19,999	27,294	12.5%
$20,000 to $29,999	28,432	13.1%
$30,000 to $39,999	27,717	12.7%
$40,000 to $49,999	23,211	10.7%
$50,000 to $59,999	20,928	9.6%
$60,000 to $74,999	23,688	10.9%
$75,000 to $99,999	22,854	10.5%
$100,000 to $149,999	15,636	7.2%
$150,000 to $199,999	4,391	2.0%
$200,000 or more	4,670	2.1%
Median household income	$42,304	

Residence in 1995

Residence in 1995	Number	Percent
Population 5 years and over	506,987	100.0%
Same house in 1995	295,911	58.4%
Different house, same county	133,891	26.4%
Different county, same state	46,789	9.2%
Different state	25,102	5.0%
Puerto Rico or U.S. islands	147	0.0%
Foreign country	5,147	1.0%

Travel Time To Work

	Number	Percent
Workers 16 years and over	258,414	100.0%
Less than 15 minutes	77,092	29.8%
15 to 29 minutes	107,536	41.6%
30 to 44 minutes	41,772	16.2%
45 to 59 minutes	14,418	5.6%
60 minutes or more	11,004	4.3%
Worked at home	6,592	2.6%
Mean travel time	22.4 minutes	

Housing Units

	Number	Percent
Total housing units	230,880	100.0%
Occupied housing units	217,788	94.3%
Owner occupied	152,996	66.3%
Renter occupied	64,792	28.1%
Vacant housing units	13,092	5.7%

Year Structure Built

	Number	Percent
Total housing units	230,880	100.0%
Built 1995 to March 2000	16,137	7.0%
Built 1990 to 1994	12,363	5.4%
Built 1980 to 1989	18,645	8.1%
Built 1970 to 1979	30,785	13.3%
Built 1960 to 1969	34,806	15.1%
Built 1950 to 1959	42,559	18.4%
Built 1940 to 1949	24,720	10.7%
Built 1939 or earlier	50,865	22.0%
Median year built	1959	

Value for Specified Owner-Occupied Housing Units

	Number	Percent
Specified owner-occupied housing units	142,460	100.0%
Less than $20,000	1,133	0.8%
$20,000 to $39,999	4,267	3.0%
$40,000 to $59,999	11,596	8.1%
$60,000 to $79,999	21,637	15.2%
$80,000 to $99,999	25,293	17.8%
$100,000 to $124,999	20,106	14.1%
$125,000 to $149,999	17,833	12.5%
$150,000 to $199,999	19,845	13.9%
$200,000 to $249,999	9,702	6.8%
$250,000 to $499,999	9,800	6.9%
$500,000 to $999,999	1,101	0.8%
$1,000,000 or more	147	0.1%
Median value	$109,100	

House Heating Fuel

	Number	Percent
Occupied housing units	217,788	100.0%
Utility gas	192,837	88.5%
Bottled, tank or LP gas	1,988	0.9%
Electricity	17,250	7.9%
Fuel oil, kerosene, etc	3,277	1.5%
Coal, coke or wood	372	0.2%
Solar energy or other fuel	1,609	0.7%
No fuel used	455	0.2%

Gross Rent

	Number	Percent
Specified renter-occupied housing units	64,500	100.0%
Less than $100	1,345	2.1%
$100 to $199	3,993	6.2%
$200 to $299	3,608	5.6%
$300 to $399	6,215	9.6%
$400 to $499	10,718	16.6%
$500 to $599	10,962	17.0%
$600 to $699	9,365	14.5%
$700 to $799	7,250	11.2%
$800 to $899	3,701	5.7%
$900 to $999	1,744	2.7%
$1,000 to $1,499	2,231	3.5%
$1,500 or more	764	1.2%
No cash rent	2,604	4.0%
Median gross rent	$546	
Median gross rent as a percentage of household income in 1999	25.0	

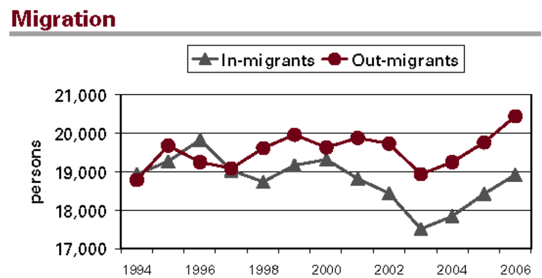
Selected Monthly Owner Costs for Specified Owner-Occupied Housing Units

	Number	Percent
Specified owner-occupied housing units with a mortgage	99,861	100.0%
Less than $400	2,577	2.6%
$400 to $599	10,069	10.1%
$600 to $799	18,445	18.5%
$800 to $999	19,667	19.7%
$1,000 to $1,249	17,769	17.8%
$1,250 to $1,499	11,726	11.7%
$1,500 to $1,999	12,141	12.2%
$2,000 to $2,999	5,807	5.8%
$3,000 or more	1,660	1.7%
Median monthly owners cost	$991	
Median monthly owners cost as a percentage of household income	21.0	

Vital Statistics

	Number	Rate
Births / rate per 1,000 women aged 15-44	6,568	59.5
Teen births / rate per 1,000 females 15-17	201	18.0
Deaths / rate per 100,000 population	5,423	992.1
Marriages / rate per 1,000 population	3,286	6.0
Divorces / rate per 1,000 population	1,781	3.3

Migration



Summit County

Agriculture

Land in farms (acres)	19,000
Number of farms	370
Average size (acres)	51
Total cash receipts	$10,860,000
Per farm	$29,351

Education

Public schools	170
Students (Average Daily Membership)	81,986
Expenditures per student	$9,623
Student-teacher ratio	18.1
Graduation rate	85.6
Teachers (Full Time Equivalent)	5,526.9
Non-public schools	42
Students	11,724
4-year public universites	1
Branches	1
2-year public colleges	0
Private universities and colleges	0
Public libraries (Main / Branches)	7 / 19

Transportation

Registered motor vehicles	522,992
Passenger cars	390,795
Noncommercial trucks	52,927
Total license revenue	$13,169,862.77
Interstate highway miles	90.34
Turnpike miles	13.61
U.S. highway miles	5.85
State highway miles	185.24
Commercial airports	4

Voting

Number of precincts	475
Number of registered voters	373,447
Voted in 2006 election	205,714
Percent turnout	55.1%

Health Care

Physicians (MDs & DOs)	1,620
Registered hospitals	9
Number of beds	2,625
Licensed nursing homes	39
Number of beds	3,936
Licensed residential care	32
Number of beds	2,452
Adults with employer-based insurance	64.7%
Children with employer-based insurance	65.4%

State Parks, Forests, Nature Preserves, And Wildlife Areas

Facilities	8
Acreage	2,585.62

Communications

Television stations	2
Radio stations	6
Daily newspapers	1
Circulation	142,600

Crime

Total crimes reported in Uniform Crime Report	23,174

Finance

FDIC insured financial institutions (HQs)	6
Assets	$11,170,368,000
Branch offices	180
Institutions represented	21

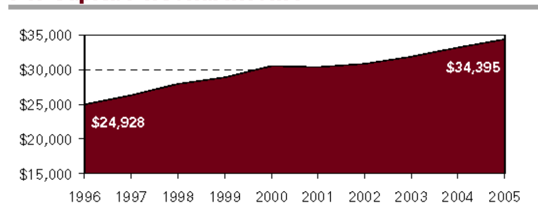
Transfer Payments

Total transfer payments	$3,106,369,000
Payments to individuals	$2,959,017,000
Retirement and disability	$1,215,407,000
Medical payments	$1,321,056,000
Income maintenance (Supplemental SSI, family assistance, food stamps, etc)	$285,977,000
Unemployment benefits	$57,609,000
Veterans benefits	$46,103,000
Federal education and training assistance	$31,879,000
Other payments to individuals	$986,000
Total personal income	$18,789,352,000
Depedency ratio	16.5%

Federal Expenditures

Direct expenditures or obligations	$3,365,056,660
Retirement and disability	$1,211,966,047
Other direct payments	$804,418,333
Grant awards	$596,681,250
Highway planning and construction	$18,281,687
Temporary assistance to needy families	$36,155,366
Medical assistance program	$334,910,646
Procurement contract awards	$568,235,040
Dept. of Defense	$507,721,267
Salary and wages	$183,755,990
Dept. of Defense	$25,778,000
Other federal assistance	$355,649,412
Direct loans	$17,104,829
Guaranteed loans	$228,429,705
Insurance	$110,114,878

Per Capita Personal Income



Regional Workshop III Feedback
Summit County, Ohio

We would like your opinion about how the workshop was designed and conducted. Please rate, on a scale of 1 to 5, your overall assessment of the workshop relative to the statements provided below, with **1** indicating **Strongly Disagree** with the statement and **5** indicating **Strongly Agree.**

Assessment Factor	Satisfaction Rating on Workshop				
	Strongly Disagree	Disagree	Undecided/ Not Applicable	Agree	Strongly Agree
1. Adequate information and instructions were provided before the workshop began.	1	2	3	4	5
2. The workshop was well structured and organized.	1	2	3	4	5
3. There was adequate time for questions and discussions.	1	2	3	4	5
4. The workshop content was relevant to my agency.	1	2	3	4	5
5. Participation in the workshop was appropriate for someone in my position.	1	2	3	4	5
6. There was adequate time for interaction with peers.	1	2	3	4	5
7. The workshop encouraged discussion between agencies.	1	2	3	4	5
8. The participants included the appropriate people in terms of the level and mix of disciplines.	1	2	3	4	5
9. The rooms were the correct size for the number of participants.	1	2	3	4	5
10. The rooms were comfortable in terms of lights, seating, and temperature.	1	2	3	4	5
11. During discussions, the facilitators and participants could be heard.	1	2	3	4	5

Please see reverse side for additional comments.

Please provide recommendations on how the workshop could be improved or enhanced:

Additional Comments:

This evaluation form is a modified version of a form available from the U.S. Department of Homeland Security, Office of the Assistant Secretary for Preparedness and Response. Revised 6-12-08 ORISE. Participant.

Regional Workshop III
Summit County, Ohio
Pandemic Influenza Planning
for an
Alternative Care System
September 23 – 25, 2008

Hot Wash

What was the most valuable part of the Workshop?

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How could the Workshop have been improved?

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Is there information or training related to the subject matter that you feel you still need?

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Is there a tool or procedure that can be created that would educate someone on the process of going from point A to point B in planning an alternative care system?

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What are the next steps?

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Other comments

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Comment Card

Summit County, Ohio

This Comment Card is provided for you to present any thought you would like to raise about the workshop. Please fill out the card and hand it to one of the workshop facilitators or place it in one of the baskets.

Idea:

Recommendation:

Comment Card

Summit County, Ohio

This Comment Card is provided for you to present any thought you would like to raise about the workshop. Please fill out the card and hand it to one of the workshop facilitators or place it in one of the baskets.

Idea:

Recommendation:

Alternative Care System Subcommittees

Facilities Subcommittee

Mission Statement: To identify standards for facilities for each identified option as they relate to resources, safety, feasibility and methodology in the provision of care during a pandemic influenza emergency.

Triage Subcommittee

Mission Statement: To develop criteria for patient triage based on the Alternative Care System, in order to facilitate effective patient coordination during a pandemic influenza emergency.

Transportation Subcommittee

Mission Statement: To assess potential sources for transportation assistance and then develop a systematic and efficient approach to the transportation of individuals for healthcare based on each option, during a pandemic influenza emergency.

Health/Hospitals Subcommittee

Mission Statement: To develop a framework for the process of addressing shared health/hospital responsibilities.

Legal Subcommittee

Mission Statement: To explore and advise on current legal components of preparedness and response activities.

Business Community Subcommittee

Mission Statement: to be developed

Participants: to be developed

At-Risk Advisory Board

Mission Statement: to be developed

Participants: to be developed