Health and Medical Subpanel of the Secure Commonwealth Panel

Meeting Minutes

DATE: April 1, 2008
TIME: 1 p.m. – 4 p.m.

PARTICIPATION	
AGENCY	**REPRESENTATIVE**
VA Department of Health	Kim Allan
American Academy of Pediatrics	Sam Bartle
University of Virginia	Ruth Bernheim
VA Department of Health	Bill Berthrong
VA Department of Health	Gary Brown
MedResolve, Inc.	Lonnie Byrd
Hampton Roads Metropolitan Medical Response System	William Ginnow
VA Hospital & Healthcare Association	Mark Dietz
VA Governor's Office of Commonwealth Preparedness	Curtis Brown
Henrico Doctors' Hospital	Courtney Cosby
Inova Health System	Diane Doyle
VA Hospital & Healthcare Association	Steve Ennis
VCU-MCV	Michael Gonzalez
VA Department of Health, Office of the Chief Medical Examiner	William Gormley
MCV	Robin Luffman
VPCA	Neal Graham
Medical Society of Virginia	Dr. Norris Royston, Jr.
VA Department of Labor & Industry	Ron Graham
Office of the Attorney General	Robin Kurz
VA Department of Health	Lisa Hague
VA Department of Health	Steve Harrison
VA Department of Health	Diane Helentjaris
VA Department of Health	A.J. Hostetler
VA HHS Secretary's Office	Gail Jaspen
VA Department of Health	Lisa Kaplowitz
VA Department of Health	Mark Levine
University of Virginia	Marcus Martin
VAVRS	Carol Rhodes
VA Poison Center	Rutherfoord (Ruddy) Rose
VA Department of Mental Health, Mental Retardation & Substance Abuse	Beth Nelson
VA Department of Health	Bill Nelson
VA House of Delegates	John O'Bannon
VA Division of Consolidated Laboratory Services	Jim Pearson
York County Department of Fire & Life Support	Michael Player
Western VA EMS Council	Morris Reece
County of Henrico, VA, Police	Henry Stanley
CVC, Inc.	Fred Norman

Inova Fairfax Hospital	James Sides
VA Department of Health	Suzi Silverstein
VA Department of Health	Linda Taylor

Purpose

Speakers:

- Commander Sumner Bossler, Senior Public Health Analyst, Healthcare Systems Preparedness, US Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response, Office of Preparedness and Emergency Operations
- Lisa G. Kaplowitz, MD, MSHA, Deputy Commissioner of Emergency Preparedness and Response, Virginia Department of Health
- Morris Reece, Near Southwest Hospital Coordinator
- Steven D. Gravely, Troutman Sanders, LLP

Cmdr Bossler presented a federal perspective on hospital preparedness including progress to date and issues that still are outstanding. The Panel was asked to consider what actions and planning they needed to consider in light of the new direction of preparedness legislation and requirements contained therein for measuring performance and effectiveness of dollars going into the program.

Dr. Kaplowitz presented current status of preparedness in the Commonwealth and also called upon the Panel to provide feedback and guidance on what they perceived as gaps in efforts that remain and what projects should be priority that will produce meaningful and measurable results.

Steve Gravely presented a summary of recent liability legislation to protect health care providers during emergencies and offered related efforts by hospitals to plan for workforce shortage challenges during emergencies.

Discussion

Cmdr Bossler – partnership grants – primarily reflect those states that had already initiated partnerships within their regions felt slighted that extra funding was for work already underway an this took away fro states base funding.

Interoperable communications among healthcare providers and public health is high priority project. It there push to include other responders in interoperable communications efforts? Fire, policy, local emergency managers. This is through SAFECOM.

Where do you think the program will be in five years? Currently, there is funding available until 2011. Earlier grants not effective in demonstrating effectiveness through defined measures. Future years will require performance measures and demonstrated efforts of improvements. There is currently no central depository of states' accomplishments to demonstrate what's been done because critical benchmarks were changed each year. A data evaluation group has been formed to evaluate 2002-2006 data already collected to try to compile into some format that is helpful.

When will various grant measure start integrating across grants e.g. EEGS, HSEEP, TCLs, NEXUS? Issue with not being able to fun back-fill and overtime to allow stats to meet exercise and training requirements among staff.

Data collection and hospital program maintenance. Must hospitals report to NIMCAST? No
Caution that program expectations are too great for what private hospitals can realistically achieve. Interesting to know where our gaps are in preparedness.

Dr. Kaplowitz
Virginia has achieved a 10 out of 10 rating on the most recent Trust for America report and 97 out of 100 possible points for our Strategic National Stockpile rating score (the highest in the nation tied with 3 other states). The CDC is also using Virginia to test their own SNS staff for competencies in deploying SNS.

Virginia has an antiviral stockpile in place. We are negotiating with health plans to coordinate antiviral availability during an event Health plans would provide coverage for those with insurance and health departments could assist those that are uninsured.

Planning gaps still exist on the topic of how to engage all health care providers in emergency response e.g. include private practitioners, staff of hospitals not usually involved in response. Continuing to try to encourage more public/private partnerships and increase engagement of local governments in preparedness and planning initiatives. Dr. Kaplowitz asked the participants, what do they think are meaningful ways to measure progress and improvements in preparedness and planning?

Challenges: 1) Targeted supplemental Pan Flu funding is being eliminated – how will we continue to support efforts in this arena that also apply to all hazards, 2) how will we fund shelf life extension of antivirals? Roche has extended (on its own accord) its supplies, but the states are responsible for re labeling the product for it to be eligible.

Where is greatest shortfall resulting from elimination of Pan Flu funding? The more you incorporate Pan Flu into basic planning, the more effective you will be. We need to maintain partnerships developed initially related to Pan Flu – including those with the Department of Human Resources private businesses, schools utilities and keep them engaged by demonstrating this preparedness applies to any potential response situation. We are looking for ideas for priority projects along these lines, what will be meaningful, practical and that can be accomplished.

Morris Reece
Presented draft document "Supply Caches for Trauma and Burn Mass Casualties." This document incorporates experiences of physicians, nurses, hospital administrators, the military and the Israelis. The guiding principle of these guidelines is "the greatest good for the greatest number of people". Assumes 50 patients per 1 million population. The key will be to train EMS when and where to deliver patients – needs carryover into pre-hospital operations including 911 call centers and EMS providers.

Question is whether current evaluation tools for <500 people appropriate or are there different tools/process for >500 casualties. Current tools apply to level I and Level II situations and Level III is bypassed. "Expectant" casualties are those that are not likely to survive no matter what the circumstances. The general public is not necessarily

accepting of that concept to handle expectant patients differently from others. The results will mean that those that could survive won't if we don't deal with the expectant patients in a different manner during mass casualty events. The ultimate decision will be dictated by the realty at the scene. Up to 80% of casualties will arrive at a hospital on their own, but will not have severe injuries. The plan relies on situational awareness, requires good communications. Communications need to be improved. The flow chart in the plan is specific to stockpiling trauma supplies. Hospitals need to define their surge capabilities to include staff and facility support. Question for the group is how we engage personnel (providers) to assist during surge events. We need to get hospitals to better define what surge they can accommodate. June 6, 2008 is the date for a final report.

Steve Gravely
Only one of 4-6 states has provider liability protections in law. The 2008 Virginia General Assembly passed legislation (HB 403/SB657) providing liability protection to healthcare providers in times of declared emergency when they are practicing under significant resource shortage situations due to the emergency which impacts the care provided. This legislation was signed by Governor Kaine and will take effect on July 1, 2008. It is not limited to victims of the event but to "any person" or "any health care provider" impacted as a result of the event. Protection applies to errors of commission and omission. Arguably, this also means it covers "withdrawal of care". The law will be in effect State or Local declarations of emergencies, even if retroactive. Protection is tied to scarcity of resources due to an event or the impact of the event. Protection extends not to what you will be able to do but what you won't be able to do during as a result of lack of resources. This legislation will put a magnifying glass on what the state (and everyone) is doing to plan for this scarcity of resource situation. The need will be to demonstrate that appropriate efforts are being made to plan and compensate as best as possible for these situations. Still not covered are institutional liability and corporate liability protections.

The Virginia Hospital and Healthcare Association continues to assess both human resources and altered standards of care issues for hospitals during a pandemic of influenza. Both the human resources and altered standards of care workgroups met to review and discuss documents developed by each workgroup. The Critical Resource Shortage Guide continues to be updated and hopefully can be implemented on a trial basis in targeted hospitals in the future. A number of policy statements have been developed. Additional meetings with an IT group are planned to explore more specifics related to technology.

Question was asked if certified emergency medical providers were included within the definition of health care provider in the VA Code. Not specifically, but they are possibly included (and protected) as part of the EMS code sections. Uninvited providers showing up at a scene in the field are covered under the Good Samaritan section of the Code. Worker's Compensation (WC) came up in the context of outside work assignment. If under a work assignment, then potentially WC applies.

Any progress in developing preparedness efforts as part of SOLs for K-12? Currently working with school systems on closure policy in the context of a Pandemic Flu outbreak. The Right Virginia campaign initiatives could expand work with all Virginians for all preparedness planning. A model to follow: Rabies Awareness Campaign.

Work needs to continue with regard to communications to the public and outreach to the public on personal preparedness as well as informing them of planning efforts and situations that will occur during events.

Next Steps

Panel members were asked to provide any additional ideas, thoughts or comments for future planning and performance tracking of preparedness efforts via e-mail, phone or mail to Dr. Kaplowitz at lisa.kaplowitz@vdh.virginia.gov, 804-864-7026 or VDH/EPR, 109 Governor Street, 13th Floor, Richmond, VA 23219. In addition, to please review the information provided and share it with staff, employees, planning partners and others in local preparedness efforts.

The agenda planning committee for the Health and Medical Subpanel will meet shortly to being planning for the next quarterly meeting of this Panel. Please submit any ideas or questions for discussion to be included on the agenda Dr. Kaplowitz as soon as possible.