PROMISING PRACTICES IN STATE SURVEY AGENCIES

Emergency Preparedness Practices

Massachusetts

Summary

The Division of Health Care Quality (DHCQ) of the Massachusetts Department of Public Health is collaborating with multiple agencies and organizations throughout Massachusetts to develop and implement a flu pandemic preparedness plan for health care providers. DHCQ is assisting with the identification and licensing of influenza specialty care units, or ISCUs, which are designed to help acute care hospitals handle overflow patients if a flu pandemic were to strike. DHCQ also is working to ensure that hospitals, LTC providers, and other health care providers have operable Continuity of Operations Plans (COOPs) that include plans on managing a flu pandemic.

Introduction

This report describes the Massachusetts State Survey Agency's role in statewide collaborative efforts to establish ISCUs and otherwise prepare for the possibility of a flu pandemic. DHCQ's efforts, the impact of these efforts, and lessons learned that might benefit others are discussed. The information presented is based on interviews with DHCQ management staff and review of selected materials.

Background

A series of conferences on flu pandemic preparedness held in 2006 by the Massachusetts Governor's Office in conjunction with leadership from Health and Human Services and Public Safety helped launch a statewide effort to establish ISCUs and implement other plans to handle a potential pandemic.

Using software from the Centers for Disease Control (CDC), staff from the Emergency Preparedness Bureau (EPB) at the Massachusetts Department of Public Health projected incident rates, fatality rates, and hospital utilization rates under various flu pandemic scenarios. These data demonstrated the need for additional hospital capacity to help manage pandemic overflow patients, and led to the planned implementation of a regulation to establish alternate care sites, referred to as ISCUs, for all acute care hospitals in the state. Every community in the state was assigned to a hospital for purposes of ISCU planning and response. A single hospital and its assigned communities form a hospital-based cluster, with each cluster responsible for a single ISCU.

Intervention

DHCQ is collaborating with hospitals and multiple state and local entities, led by the EPB's Hospital Preparedness Coordinator and six regional coordinators, to license an ISCU location for each of the 73 acute care hospitals in the state. The majority of ISCU locations are schools, often based out of the gymnasium, as schools typically meet the necessary criteria (e.g., access to food preparation and dining facilities, availability of rooms with the capacity to hold large numbers of people). It is estimated that ISCUs would be in use for approximately two to four weeks under a flu pandemic situation. The ISCU locations continue their typical operations until they are needed for ISCU purposes. Schools designated as ISCUs are encouraged to collaborate with local schools not serving as ISCUs to plan in advance where students would attend school if the ISCU were activated and the school system was still in operation.

An ISCU is licensed as a satellite facility of the partnering hospital and is intended to supply additional space for outpatient screening and inpatient care to flu patients too sick to be cared

for at home but who do not meet criteria for hospital admission. By establishing the ISCU as a satellite unit of the state licensed and Medicare-certified hospital, hospital reimbursement will not be disrupted. Hospitals assume management responsibility for the ISCUs. Flu pandemic preparedness committees are pursuing special legislative appropriation to provide funds for beds and other equipment for the ISCUs.

Staffing the ISCUs is recognized to be a significant challenge. If a flu pandemic occurs, the health care workforce will be in high demand and at the same time likely will be reduced as workers or their family members may be affected by the flu. Difficulties therefore are anticipated with regard to reaching the ideal number of staff for each ISCU as well securing staff with the preferred level of health care expertise and experience. ISCUs likely will require volunteer staffing, including Medical Reserve Corps units, former health care providers, and individuals who do not have health care experience. Local boards of health in each hospital's cluster are anticipated to play a major role in recruiting volunteers to serve as ISCU staff. A statewide health care volunteer registry (Massachusetts System for Advance Registration, or MSAR) being developed by the EPB with funding from the federal Emergency System for Advance Registration of Health Professions Volunteers (ESAR-VHP) program also should serve as a useful resource. DHCQ's own continuity of operations plan states that, in the case of a flu pandemic, surveyors would be transitioned into direct care roles (e.g., at ISCUs). The survey agency would substantially curtail team survey activities, although retaining the capacity to investigate complaints, so that clinical staff could be redeployed to assist with such clinical work.

DHCQ is responsible for licensing each hospital's ISCU. DHCQ staff also participate on several subcommittees working to address issues associated with the ISCUs. For example, DHCQ is collaborating with the Department of Public Safety to determine whether regulatory changes will be required to allow buildings not certified for health care occupancy (e.g., the majority of schools) to serve as ISCUs.

DHCQ also is leading an effort to ensure that long-term care (LTC) facilities have updated and operational COOPs that meet state requirements, including plans for managing a flu pandemic. DHCQ sent a letter informing LTC providers of the obligation to develop a COOP and is supporting providers' efforts to meet this requirement by collaborating with the local nursing home provider associations and participating in a joint public-private committee of stakeholders organized by the provider associations to identify provider needs, communicate regarding emergency preparedness and COOP issues, and supply training to providers.

In 2006, DHCQ designed and implemented a provider review tool to be completed by each LTC provider every two years. The document delineates the elements that must be addressed in each provider's COOP (e.g., COOP activation/deactivation criteria, essential functions, order of succession, communication plans, and pandemic preparation) in accordance with state and federal emergency preparedness requirements, and includes an attestation confirming that the provider has developed a COOP that includes the listed elements. The document is designed as an all-hazard emergency preparedness educational tool and an ongoing regulatory enforcement tool. Surveyors use the provider review tool to assess COOP adequacy at each LTC facility annual recertification survey, with the initial roll-out focused on guidance and education. Ongoing use will be both educational and supportive of regulatory enforcement efforts.

DHCQ also is collaborating with the Mass Extended Care Federation, the MassAging Association, and various providers and state agencies in the process of enhancing LTCF providers' all-hazard preparedness, including development of mutual aid agreements among LTCF providers for pandemic and other hazards. A key objective of the agreements is to ensure adequate staffing during a flu pandemic or other emergency situation for all providers. Based on CDC estimates of a 40 percent reduction in staff associated with flu pandemic (due to staff illness or their need to care for ill family members),

DHCQ is encouraging providers to plan strategies to ensure that basic functions would be covered if staffing resources were limited to such a degree. Providers are encouraged to act now to coordinate arrangements with nearby facilities to share staff, thereby distributing limited staffing resources to ensure at least minimal coverage at each collaborating facility rather than leaving individual facilities to work within the staffing patterns that occur.

Implementation

Implementation of the ISCU model began in early 2006. Initial activities focused on hospitals identifying ISCU locations and establishing agreements with those locations. Hospitals were requested to submit to DHCQ an application for licensure approval of their designated ISCU and a Memorandum of Understanding between the hospital and the entity that owns or controls the space in which the ISCU is to be located (e.g., school system), by the end of 2006. DHCQ and EPB collaborated to develop an *Emergency Influenza Specialty Care Unit (ISCU) Preparation Checklist* to assist hospitals with meeting ISCU requirements.

DHCQ is one of multiple entities across the state collaborating on the effective design and implementation of ISCUs. Several flu pandemic preparedness committees continue to work on various aspects of ISCU implementation, particularly the critical challenge of staffing the ISCUs.

DHCQ developed the COOP provider review tool to support providers in developing their COOPs to meet state and federal emergency preparedness requirements and standards of practice. Requiring providers to complete the tool every two years will promote efforts to keep COOPs current and operational over time.

Impact

The collaborative efforts of DHCQ and multiple other entities across the state have resulted in substantial headway in preparing health care providers for the possibility of a flu pandemic. Eighty-one percent of hospitals in the state have submitted their application for licensure approval of the ISCU site (as of September 2007). Although staffing the ISCUs remains a concern, ISCU planning activities have raised awareness of this issue and efforts to address the problem continue.

Ninety-five percent of LTC providers have submitted attestations of having a COOP. The process of developing mutual aid agreements has led many LTC providers to establish partnerships and agreed upon plans prior to the occurrence of a flu pandemic or other hazards. LTC providers also continue to work to establish contingency plans within their own facilities to help cover key functions if a drastic reduction in staff were to occur. DHCQ management staff believe that the efforts invested in COOP development activities has promoted the evolution of a positive culture of all-hazard cooperation and support within the LTC industry, across healthcare provider types, among various private stakeholders and with the responsible state agencies.

Lessons Learned

It is critical to anticipate and carefully plan in advance for potential emergency situations. DHCQ management staff advocate for directly involving providers in a collaborative process toward achieving preparedness. In planning for ISCUs, it is important to explicitly acknowledge hospitals' potential concerns regarding their capacity to run an effective ISCU and provide high quality of care with only limited, and likely largely volunteer, staffing as well as other constraints. It is valuable to recognize that many issues beyond the control of the hospital are likely to arise. Hospitals, however, should be prepared to open an ISCU even without ideal staffing or other care factors. It is important to work with hospitals to ensure that they understand and accept that, in light of such issues, an altered standard of care is expected, and ideal care is not anticipated.

DHCQ management staff emphasize that productivity can be considerably greater if multiple, interrelated steps are underway concurrently and tasks are completed on the assumption that other associated tasks will be accomplished. For example, hospitals should

move forward with identifying ISCU sites and forging partnerships with those sites simultaneously with the pursuit of legislation by other parties regarding liability issues for volunteer-staffed ISCUs. Individuals involved in the planning and implementation process should resist getting overly focused on accomplishing tasks sequentially, and leadership must be prepared to continuously address reluctance to move ahead on interrelated tasks until others have been completed.

Contact Information and Resources

For more information, please contact Paul Dreyer, Director, Division of Health Care Quality, Massachusetts Department of Public Health at Paul.Dreyer@state.ma.us or 617/753-8100**.** The *Emergency Influenza Specialty Care Unit (ISCU) Preparation Checklist* developed by DHCQ and EPB can be accessed at http://www.mass.gov/Eeohhs2/docs/dph/quality/hcq_circular_letters/hospital_flu_unit_checklist.pdf

This document is part of an issue brief on emergency preparedness practices in State Survey Agencies and long-term care provider associations. The issue brief is one of a series by the Division of Health Care Policy and Research, University of Colorado Health Sciences Center, for the U.S. Centers for Medicare & Medicaid Services (CMS) highlighting promising practices in State Survey Agencies. The entire series is available online at CMS' Web site, http://www.cms.hhs.gov/SurvCertPromPractProj/. The issue briefs are intended to share information about practices used in State Survey Agencies and other organizations and are not an endorsement of any practice.