Hospital Panel: Governor Malloy’s Two-Storm Assessment
Hartford Hospital
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Tropical Storm Irene:
As part of Hartford Hospital’s emergency preparedness efforts the hospital began initial planning activities in response to expected TS Irene on Wednesday August 24th. Departments reviewed their departmental preparedness plans, and contractors, vendors, suppliers, along with clinical and non-clinical staff were put on alert for potential activation in support of anticipated resource needs. A Hurricane Preparedness Meeting was called by the hospital’s CEO Jeff Flaks to discuss preparedness activities. The hospital’s Emergency Operations Plan and Hospital Command Center were activated through the weekend. Anticipating that travel would be difficult on Sunday morning, additional clinical and support staff were called into the hospital Saturday evening to support potential medical surge on Sunday, and a staff shelter was established to provide overnight accommodations for those staff members. The HCC operated until 3pm on Sunday, with a total of 44 staff members activated to the HCC to fill a variety of Command, General Staff, and Hospital Incident Command System positions.

Challenges: A collapsed City of Hartford sewage line under Retreat Avenue, combined with the volume of rain, caused the sewer system to back up into the basement level of the hospital and required significant clean up and restoration efforts; Hartford Hospital was able to reach out to community partners (Hartford Fire, Hartford City MDC) and vendors to identify sources for sandbags and pumps.

Communication: Multiple safety messages were developed to help keep staff, patients, family and visitors informed throughout the incident. Distribution included electronic media, but were also printed in both English and Spanish and hand distributed to patient floors.

Staffing: The incident did not result in more than a few storm-related patient admissions, and the additional support staff brought in, in anticipation of a potential medical surge, was more than adequate to meet the needs of all patients. Most of the storm related admissions were secondary to oxygen-dependent patients without power, and the inability of oxygen vendors to keep up with the increased demand for portable oxygen sources. As well, one ventilator patient without generator power at home arrived within 2 hours of her battery backup failing. This admission required a step-down level of care.

Community Pharmacies: Closed on Saturday and early Sunday in preparation for the expected storm landfall. This prevented emergency department patients to be released/discharged home with prescriptions that could not be filled. HCC worked with hospital pharmacy and CT DPH to develop a policy permitting prescriptions to be filled onsite by Hartford Hospital pharmacy with a temporary (3-day) supply of medication.
This exemplary example of integrated problem solving involving multiple departments facilitated the ongoing delivery of safe and effective patient care.

**New York Hospital Evacuation:** Based on an emergent need, Hartford Hospital was quickly able to accept a number of critical care patients from a New York hospital under evacuation, facilitating timely and safe care management.

**Winter Storm Alfred**
The rapidly increasing volume of patients presenting to Hartford Hospital Emergency Department required careful planning, day by day, minute by minute in order to effectively and safely manage all patient care needs. The planning necessitated creativity that went well beyond the hospital’s existing surge plan.

In 2007, in collaboration with a multidisciplinary Capacity and Throughput Team, Hartford Hospital leadership developed a Hospital Surge Response to Bed Emergency. This plan includes operational capacity levels, as well as individual roles and responsibilities by department and is meant to manage capacity and throughput day to day, with a heightened response during any increased demand for inpatient beds. Bed huddles occur daily regardless of demand for beds, and during this emergency, the team met several times during each day to communicate all pending discharges, assess patient movement, identify any delay in patient throughput to and from all areas, and to determine next steps regarding surgical scheduling, staffing, and best placement of each patient.

**Existing and available surge capacity:** the hospital is able to surge up and accommodate approximately 24 additional beds on any given day based on patient needs, Emergency department volume and number of inpatient boarders. An Emergency Department pod, based on the number of inpatient boarders, can be converted to an inpatient area, with additional resources deployed from the STAR (float) team, other inpatient units, and calling in additional staff resources.

**When Demand Exceeded Capacity:**

**Additional Surge Areas Created in Response to Heightened Needs:**
- Conklin Building 1-an area reserved for Cardiac Rehabilitation-transformed in less than 12 hours into a discharge area for patients ready to return home, yet could not do so due to loss of power: staffed with RN’s, this area was able to accommodate 10 persons
- Educational Resource Center- 35 dormitory rooms available for discharged patients. For independent persons, no care provisions available.
- Emergency Department Admissions Unit-for admitted patients (boarders). This unit was created in less than 24 hours and involved erecting a wall in our Emergency Department Waiting Room to provide space for up to 10 admitted inpatients. This area is fully equipped to allow inpatient care delivery, including standard emergency equipment, and telemetry.
Staffing:

- Maximizing staffing levels included the activation of our Weather Advisory Policy; all employees on duty at the time of a weather advisory may be required to remain past the end of the assigned shift to ensure appropriate staffing levels to provide patient care. An employee scheduled to work who does not report for work, or has not been excused by management, during a weather advisory will not be paid, except due to extraordinary situations (if approved).
- STAR Team: A float team of nurses trained in coverage of all units, including the Emergency Department and all critical care areas. This team is instrumental in assisting with our day-to-day staffing and coverage needs, and most importantly, assisting with coverage during crises.
- Staff Commitment: Commendable work on the part of nursing leadership and their staff nurses and all support staff. Many came in early, stayed late to meet the needs of our patients, despite the multiple challenges they faced at home.
- Case Coordination: Additional case management resources were deployed to the Emergency Department, working closely with social work staff to identify plans for the non-acute, but medically compromised patient unable to go home due to loss of power. Typical case volume each day was between 10 and 15 patients at any one time. Most required SNF placement, as the above defined surge areas would not meet their needs.
- Staff Accommodations: Cots were placed in Heublein Hall and nursing unit conference rooms to accommodate staff overnight. The dormitory rooms in ERC were reserved for discharged patient use.
- Child Care: Thursday and Friday (November 3rd and 4th) hospital administration recognized the need to assist staff in child care accommodations and quickly responded by planning and organizing this activity for 150 children of staff members.

Discharge Challenges Specific to Most Recent Storm:

- The volume of patients transitioned to SNF’s increased significantly (from all hospitals) and bed capacity was quickly overwhelmed. As well, several facilities reported generator failures that prevented the timely transition of patients.
- SNF’s with associated Assisted Living Facilities had to work with power outage problems in those settings before accepting hospital inpatients, decreasing further the number of available beds.
- Phone service interruption: one SNF lost telephone access later in the week, and thus were unable to accept patients safely into their building by order of the DPH. Other facilities also experienced phone access problems, hampering the ability of hospitals to call nursing reports and facilitate safe and timely transition.
- By week’s end, many facilities were full and unable to accept new patients through the weekend (as unable to discharge their own patients into the communities where there was still no power).
- Discharge Transportation: Ambulance, wheelchair van and taxi transports were overwhelmed with the number of calls, and the delayed response affected many
discharges. Specifically problematic was the increased number of 911 calls to ambulance providers, which directly impacts patient discharge flow.

- The inability to track the return of power to any given area hampered the ability to facilitate timely transition home.

**Opportunities for Improvement:**

- Hospitals did not have real-time information on the SNF’s able to surge up, and could rely only on the usual referral and acceptance process.
- Medical Necessity for SNF stay: the Hospital experienced difficulty with many commercial payers in securing authorization for those patients requiring a facility for safe care, but who failed to meet medical necessity for the level of care. Cases were either denied or hospital case managers were unable to reach assigned case managers.
- When patients did not meet medical necessity requirements for SNF care, the Hospital developed one-time contracts with several facilities for 7 distinct patients in order to ensure coverage for the costs of care for 3-5 days, in order to facilitate timely and safe transition.
- The expressed concerns (from many SNF’s) related to reimbursement (or potential lack thereof) was the dominating theme throughout the week.
- MIMR and Level of Care Process: delayed transition of patients to SNF’s. Ascend delays occurred in onsite evaluations of patients who were discharge ready.

**Summary and Conclusions:**

Hospitals facing bed crises of potentially disaster proportions calls for a focused and rapid response by internal leadership, and one that cascades throughout the organization; at the same time, the hospitals must be able to trust that their state and local governments, other community healthcare providers and related service organizations are working in an organized fashion. The daily conference call with DPH and the other hospitals in Region 3 provided a forum during which hospitals could express issues related to exhausted capacity, resources, and safety concerns. Proactive planning in anticipation of a potentially overwhelming situation is critical. As well, Hospitals must have the confidence in a proactive response by all community providers, carefully guided by their state and local agencies in order to effect the safe and timely transition of every patient. Streamlining the regulatory requirements associated with each SNF placement when Hospitals are under such crises would be best if more prescriptive, and included waiving level of care requirements, assuring reimbursement for nursing home days, strategically and carefully managing the direction to SNF’s to allow them to surge up (considering the safe staffing levels in order to accommodate such a directive) and ensuring full cooperation with all commercial payers to waive the specific Interqual or Milliman criteria guidelines that otherwise hamper efforts to effect timely discharge; these measures would all work to decompress overburdened emergency rooms and facilitate patient throughput overall.

Moreover, the activation of community resources that are aligned better with the needs of the healthcare community is critical; areas where power restoration was delayed included towns that are resource-rich in terms of available SNF beds. Concerns regarding generator failures, staffing challenges unable to accommodate surging beyond licensed
bed capacity, inadequate phone access into the facilities, and the expressed concern of potentially not being reimbursed for level of care issues and lack of medical necessity all worked to slow down the process.

Despite the barriers, hospital discharges remained on track for the week; a total of 707 patients were safely transitioned last week. Despite the need for creative planning and discharge coordination, 38.5% of patients were still discharged prior to 12 noon. The hospital’s OR schedule remained uninterrupted, and timely transition of patients from the PACU to the nursing units occurred safely and with rare delays.